RAPE ASSESSMENT SCHEDULE: DEVELOPMENT AND PILOTING

by

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Introduction

One of the many myths which has been traditionally held is that rape is a sexual crime, a crime perpetrated by a man who had become overwhelmed by sexual impulses. However, this myth is slowly losing favor, especially in the academic community, and rape has been redefined by many as a crime of violence. Much of the impetus for this redefinition came from the work of Susan Brownmiller who has written a feminist analysis of the history and occurrence of rape (1975). Brownmiller has pointed out that throughout history rape has been been associated with male violence and dominance; it has been used as the ultimate weapon in the establishment of victory over conquered nations/people, as an instrument of insult to the man who "owns" the raped women, and as a threat/tool to keep women in their subservient role.

Brownmiller's thesis has been supported by research which has indicated that most rapists have adequate sexual relationships and that rapist show no typical pattern of abnormality or topograghy (see Dean & deBruyn-Kops, 1982 for review). In addition, a study by Sanday (1981) of the cross-cultural occurrence of rape has indicated that cultures with the highest incidence of rape are characterized by the approval of interpersonal violence, male dominance, and sexual separation. Societies which have little or no rape, on the

other hand, are characterized by sexual equality, a mutual valuing of female/male roles, and social condemnation of interpersonal violence. Sanday's conclusions were based on her analysis of 156 modern and "primitive" cultures.

With consideration of this research it has become increasingly common for researchers interested in rape to define it as an act of violence rather than an act of sexual release. For example, in a 1981 issue of the Journal of Social Issues devoted to the topic of rape (December, 1981) all contributors employed the "rape as violence" definition and this will be the definition employed here. In addition, within the context of the current project the raped woman has been referred to as a survivor of rather than as a victim of rape. While the latter label is, by far, the most commonly used, I have not done so in an attempt to avoid the negative connotations of the word victim.

Victim is most generally used to refer to individuals who have been irreparably damaged, killed, or who are currently under attack by some deleterious force; thus, we refer to victims of incurable disease, victims of murder, and victims of war. Conversely, the term survivor is most generally used to refer to individuals who have overcome or lived through interactions with deleterious forces; thus, we refer to survivors of accidents, survivors of war, and survivors of natural disasters (e.g. floods, tornadoes, etc.). Since I do not feel that the images of damage/death apply to the raped

woman, the term survivor with its associated images of stregth/life has been used.

In spite of the long history and present prevalence of rape, surprisingly little is known about the long-term psychological effects of this violent phenomena on the survivor. Research on these psychological effects of rape is a relatively new area of interest in the field of psychology. Since current statistics indicate that one in every three women will be raped in her lifetime (Bristow, 1982), it is vital that we know more about the nature and course of a survivor's reaction to rape. To gain this knowledge, the nature of social, cognitive, situational and affective variables and the role that these factors play in the rape survivor's overall adjustment process must be investigated. The current project will attempt to develop a structured interview schedule to be used to investigate the long-term psychological effects of rape on the survivor.

Initial Reactions to Rape

The survivor's initial reaction to the rape event has been characterized as having two or three distinct phases. Sutherland and Scherl (1970) interviewed 13 young women (age 18-24 years) who the authors stated had backgrounds "consistent with accomplishment, independence and psychological health (p. 504)", a statement apparently made by the authors to indicate that the women were well adjusted prior to the rape event. Based on these interviews, the

authors proposed a three-stage process of survivor reaction. Phase one, the acute reaction, is characterized by shock, dismay, gross anxiety and other forms of acute distress and endures from a few days to a few weeks. In phase two the symptoms of distress are replaced by denial, suppression and rationalization and the survivor appears to have adjusted and returns to normal activity. Phase three begins when the survivor becomes depressed and develops a need to talk, and the authors state that two major themes emerge for resolution in this phase: the survivor must integrate the rape event to form a new view of herself, and the survivor must resolve her feelings about her assailant(s). The authors do not clearly document or describe the reactions in phase three, the duration of this phase, or the nature of the changes in the woman's psychological and social functioning that are produced by the "resolution".

Burgess and Holmstrom (1974) interviewed 92 adult survivors of rape. These women were interviewed at the hospital directly after the rape, by phone or home visit weekly for three months and again at six months, nine months and one year post-assault. The authors described the survivors' typical reaction to rape (The Rape Trauma Syndrome) as having two distinct phases. The first or acute phase endures for two-three weeks and is characterized by an extreme disorganization in the survivors' life: feelings of extreme tension, fear, humiliation, anger, self-blame and

embarrassment are often reported. The second phase is desribed as a reorganization of the survivors' lifestyle and often results in changes that may be permanent. Among long-term changes noted by Burgess and Holmstom were disturbing nightmares, the development of rape related phobias and restrictions in lifestyle. Furthermore, the authors stated that survivors who had either a past or current history of physical, psychiatric or social difficulties often developed additional symptoms that included depression, psychotic behavior, psychosomatic disorders, suicidal behavior, alcoholism, increased drug use and sexual difficulties.

As mentioned, very little is actually known about the duration of this "integration" or "resolution" phase of the survivor's reaction to rape or about the nature and permanence of the resultant psychological changes and adjustments. While researchers have begun to study the post-assault interval they have typically focused on the first one to two years post-assault and, therefore, have defined long-term by these parameters. Of course, given that the interest in the psychological effects of rape is relatively new, one might expect the relevant literature to be somewhat limited in scope. The existing research on the psychological effects of rape will be reviewed herein in an order specified by the length of the post-assault interval investigated; the study with the shortest interval will be reviewed first and so on.

The psychological effects of rape will then be compared to the psychological effects of involvement in other forms of trauma. A critique of the current research on rape and a discussion of the relevance of this project will follow.

Longer-term Reactions to Rape

The short-term effects of rape on the survivors sexual functioning and satisfaction has been investigated (Feldman-Summers, Gordon, and Meagher, 1979). In this study, the sexual activity level and sexual satisfaction of 15 survivors was assessed at two months post-assault with the use of questionnaires: the women were used as their own controls. These women reported that their level of sexual activity was comparable to pre-assault levels, but their sexual satisfaction had decreased considerably. Sexual problems that decreased sexual satisfaction included aversion to sexual activity, especially to sexual acts demanded by the rapist, feelings of unpleasantness, lack of orgasm, and flashbacks to the rape event. The women reported few problems with affectionate rather then sexual displays of love such as hand-holding and hugging.

In a 1979 study Kilpatrick, Vernon and Resick used a number of objective measures of mood and emotion {e.g. The Beck Depression Inventory (BDI), The Modified Fear Survey (MFS)} to evaluate 46 recent survivors of rape, aged 16 years or older, who had sought counseling or advocacy services from People Against Rape, a rape crisis center. Data obtained from

these women 6-10 days after the rape and at one, three and six months post-assault were compared to the same data obtained from a non-victimized matched sample of women. The control women were matched to the survivors on age and racial status and lived in the neighborhood in which the matched survivor resided at the time of the rape. At six months post-assault the raped women scored significantly higher than the controls on measures of fear and anxiety. In a follow-up study of 20 of these women (Kilpatrick, Resick and Vernon, 1981) it was found that at one year post-assault the rape survivors still scored significantly higher on measures of fear, anxiety, phobic anxiety, paranoia, psychosis and obsessive-compulsion. Based on these data, which where obtained from 28 objective measures of mood and emotion (which included those used in the initial study), the authors concluded that fear and anxiety may represent long-term problems for the survivor. It should be noted that long-term could only be defined as one year, as that was the maximum post-assault interval investigated by the authors. Interestingly, some of the non-significant trends in the data prompted the authors to speculate that the survivors may have been getting worse at one year post-assault. This speculation would be consistent with the three-phase reaction to rape described by Sutherland and Scherl (1970), in which the survivor goes through a period of denial and "pseudo-adjustment" prior to the final stage of resolution and integration.

A study completed by Ellis, Atkinson and Calhoun (1981) support the results and conclusions of Kilpatrick et. al. These authors analyzed responses on self-report measures {e.g. BDI, MFS, The Social Adjustment Scale-Self Report (SAS-SR), The Pleasant Event Schedule (PES)) as well as on semi-structured interviews to assess survivor's emotions and the effects of the rape on the survivor's work, interpersonal relationships, marital and sexual functioning, health, alcohol and drug use, and general lifestyle. Data were obtained from 27 survivors who had been raped at least one year previously (mean=3 years; range=1 to 16 years) and compared to data obtained from a non-victimized matched control group. The psychological scale data indicated that the survivors were significantly more depressed, tense and fatigued than the control women. The survivors also scored significantly higher on measures of family problems and reported significantly less enjoyment of activities than the non-victimized controls. Moreover, survivors of stranger rapes were significantly more fearful than both the non-victimized controls and the survivors of non-stranger rapes. In addition to supporting the data of the Kilpatrick et. al. studies (1979; 1981) these results also indicate that these effects may endure up to three years post-assault.

A later study by this same research team (Atkeson, Calhoun, Resick, & Ellis, 1982) apparently contradicts the depression data reported above. In this study the authors

assessed the depression of 115 survivors with the use of the MFS and the Hamilton Psychiatric Scale for Depression (HPSD). The 115 survivors were assessed at one, two, four, and twelve months post-assault and this data was compared to that obtained from a matched control group. The authors reported that up to four months post-assault the survivors displayed significantly more depression but that by six months post-assault survivors and non-survivors show comparable scores on depression measures. However, it should be noted that there are two important methodological differences between the two studies: The length of the post-assault interval and the number of assessments of the survivors' symptoms. Since the maximum post-assault interval investigated in the second study was one year, it is again possible that some of these women were in the denial phase of adjustment described by Sutherland and Scherl (1970) which is characterized by "pseudo-adjustment".

In another study by Resick, Calhoun, Atkesen and Ellis (1981) the authors attempted to control for what they felt might be the possible therapeutic effects of repeated assessment. In this study 93 rape survivors were tested at one, two, four, eight and twelve months post-assault. These data were then compared to that obtained from a matched control group and from three additional survivor groups who were assessed only once at either two, four, or eight months post-assault. All participants completed the SAC-SR which

yields a total adjustment score as well as subset scores in five areas of adjustment: social and leisure; marital, parental, and family unit; extended family; work; and economic. The repeated assessment survivor group (RAS) showed significantly less adjustment than the controls on the overall score and on all but the marital, parental, and family unit subscales at one and two months post-assault. However, by four months post-assault the RAS's adjustment scores had stabilized at levels similar to the non-victimized controls except that work adjustment continued to be affected through eight months post-assault. However, the single assessment survivors (SAS) showed significantly less adjustment then both the RASs and the controls at four and eight months post-assault, particularly with regard to relationships with relatives. This data seems to indicate that repeated assessment of rape survivors can be therapeutic. Furthermore, the disappearance of the RAS's negative effects at four months post-assault in this study could once again indicate a progression into the denial phase of apparent adjustment (Sutherland and Sherl, 1970) rather then a completed adjustment to the rape. Data from the Ellis et. al. study (1981) in which relatively long-term survivors of rape were tested and found to be significantly more depressed, tense, and fatigued then control women could be interpreted as support for this notion.

Brodsky (1976) reported on five case studies of raped

women who were receiving therapy after they had been raped while at work. Up to two years post-assault (range of intervals=six to twenty-four months) these women reported unusual amounts of fear, nervousness, anger, paranoia and depression as well as nightmares, an increase in the use of drugs and alcohol, marital and sexual difficulties, a variety of health problems, and difficulty relating to men. The exact duration of these effects is unknown as the case histories were reported by Brodsky before the women had completed therapy; the problems were, therefore, still ongoing. Brodsky speculates that women who are raped on "safe" ground (i.e. work place, home, etc.) may have more severe reactions to rape than women who are raped on "unsafe" ground (i.e. a park, dangerous areas of town, etc.). While this speculation is as yet untested, data from the studies cited herein have indicated similar effects in samples of women who had been raped on "unsafe" as well as on "safe" ground and might be used to argue that the place of the rape is irrelevant to the survivors reaction. However, before any conclusive statements concerning this variable can be made, research which analyses survivor reaction in terms of place of rape must be completed.

Burgess and Holmstrom (1979a) interviewed 81 survivors 4-6 years post-assault and asked them the time it took them to recover sexually after the assault. These subjects were from the original subject pool used in the authors 1974 study on

the Rape Trauma Syndrome. Twenty-nine women reported that recovery had taken months, thirty of the women reported that recovery had taken years, and 21 of the survivors reported that they had not recovered. Sexual problems mentioned by the survivors included an aversion to sexual activity, boredom, unpleasantness, lack of orgasm, and flashbacks to the rape event. These authors (1979b) also interviewed these same 81 women to determine the time it took for general recovery and to study the relationship of various factors and coping strategies to overall recovery and adjustment. Thirty-seven percent of these women reported that they had recovered within months of the assault, 37% reported that the recovery had taken years, and 26% reported that they had not yet recovered. The authors reported that positive self-esteem, the use of defense mechanisms of explanation, minimization, suppression and dramatization, and an increase in activity level (for example, moving, changing jobs, etc) are associated with a faster recovery time. In addition, the display of maladaptive behaviors such as an increase of the use of drugs and alcohol or a suicide attempt after the rape are associated with a slower recovery time or a lack of recovery.

Burgess and Holmstrom speculate that a variety of social, personal and situational factors influence the nature and length of the rape survivor's recovery process. These factors included prior life stress, style of attack, relationship of survivor and offender, the amount of violence or the sexual

acts demanded, and social network response. One problem with these two Burgess and Holmstrom studies (1979a, 1979b) is that the women were not given a definition of recovery but rather they were allowed to provide their own phenomenological definition of the term. While there is nothing inherently wrong with this methodology the authors failed to ask the women to define recovery; thus, it is unclear what the individual women meant by the term "recovered".

Taken collectively, the above studies offer valuable insight into the nature of the effects of rape on the survivor's psychological functioning and life style. A critical assumption which has guided all of the above research is that the effects of rape are negative and deleterious. The logic for this assumption seems extremely tenable until one reads the opening lines of an article by Crescent Dragonwagon (1977): "About six years ago I was raped, at gunpoint and against my will, and it was probably the best thing that ever happened to me (pg. 60)". Dragonwagon emphatically states that the rape and subsequent adjustment was a "difficult, painful, terrifying experience (pg. 60)". However, she feels that the entire adjustment process to the rape and near death experience ultimately worked "the most positive and basic transformations (pg. 60)" in her. The experience caused Dragonwagon to question every premise she had ever held, it allowed her to restructure her priorities and enabled her to determine what was important in life. In the author's own

words "the {adjustment} process in itself gave me one of the keys to becoming the rarity that I am today: a genuinely happy person (pg. 60)".

An initial reaction to Dragonwagon's paper might be that she is an unusual rape survivor; indeed, Dragonwagon herself believes this to be the case. She feels that she had a more positive support system then most survivors and that she had options that few survivors have. For example, Dragonwagon was able to take a leave of absence from work and cloister herself on an isolated farm in Vermont for several months. It was during this period of isolation and "introspection" that the beginning of the remarkable transformation described by Dragonwagon occurred. Without this retreat and the loving support that she received, Dragonwagon feels that she may have been lastingly scared by the experience.

While it may be the case that Dragonwagon is an unusual rape survivor, it may also be true that other, less fortunate survivors have experienced some positive effects due to the adjustment process. The idea of growth through crisis and conflict is not new to psychology (Gilligan, 1982). Based on his research with rape survivors, Vernon Kilpatrick has suggested this possiblility but has also indicated his reluctance to openly make this statement (personal communication, 1982). Kilpatrick's fear is justified as many could perceive such a statement as an attempt to trivialize a woman's rape experience and might therefore react with

disbelief and anger. Indeed, information which concerned the positive effects of the rape experience could conceivably be used for this purpose. However, if the adjustment process can result in effects which benefit the survivor then these effects and the mechanisms that produce them must be studied.

Parallels to Other Forms of Trauma

At this point, one might wish to compare the effects of rape to the effects of other forms of violent victimization and types of traumatic experiences such as armed assault, natural disasters, serious accidents, and war related traumas. In the previously cited study by Brodsky (1976), the author compared the data she obtained from women raped at work to those she obtained from 12 men who had been "mugged" at work. The men had all of the same symptoms evidenced by the rape survivors in the Brodsky study. The men did not (could not) return to their jobs. They had fears of being alone and of walking on city streets. They drove with their car doors locked, and some of the men purchased dogs and/or guns. All the men had nightmares, avoided people, and had periods of sexual dysfunction. The men also developed phobias which were not related to their muggings, such as a fear of heights or confining spaces. Brodsky speculates that certain traumas evoke what Keiser (1968) has called aphanasis, fear of annihilation, and that any experience that involves this fear may produce similar effects.

Violent Crimes. A search of the literature for studies

which described the psychological effects of other forms of violent crimes on the survivor proved unsatisfactory. Much of the victimization research centers on factors such as the etiology of crime, characteristics of survivors and perpetrators (e.g. sex, age, income etc.), the functioning (or lack thereof) of the legal system, and the need for restitution for the survivor; the psychological effects of crime are either ignored or referred to vaguely (Hindellang, Gottfredson, & Garofalo, 1978; Parsonage, 1979). An exception to this is an 1978 book by Barkas in which the author reported interviews of survivors of various crimes (e.g. assault, armed robbery, battering and rape), criminals, judges, police officers and lawyers. One conclusion which Barkas made based on this data was that violent crimes produce four types of effects: physical, financial, social and psychological. Barkas feels that the psychological effects are most easily obscured and are therefore ignored by society; yet she feels that psychological "wounds" produced by crime can be as severe and as permanent as the other effects. Barkas noted that the common effects of the various forms of crime included anxiety, insomnia, edginess, fear, insecurity, lack of trust, and anger. Unfortunately, due to the broad scope of her book, Barkas does not fully develop the severity, course, and endurance of these effects.

Civilian and natural traumas. The psychological effects of other forms of trauma on the survivors are well documented.

In his 1968 book Keiser reviews seventy-five years of psychiatric literature on the "traumatic neurosis" (now called the Post Traumatic Stress disorder); a syndrome characterizing psychological changes in individuals following traumatic events. The traumatic neurosis is divided into two phases: first, the acute phase, lasting from a few days to six months (the traumatic syndrome); and second, the chronic phase of indeterminate length (the traumatic neurosis). Keiser stated that the traumatic syndrome (the acute phase) is characterized by many of the following symptoms: startle reactions, fearfulness, repetitive dreams or nightmares, sweating, palpitations, headache, dizziness, blackouts, insomnia, intense irritability, anxiety states, fatigue, sexual dysfunction, manifestations of fearfulness and incapacitation, and emotional anesthesia. Keiser posits that the traumatic neurosis develops if the individual is unable to regain psychological homeostasis following the trauma; the neurosis can include conditions such as hysterias, depression, hypochondriasis, anxiety hysteria, anxiety states, obsessions, and compulsions. In addition, other researchers (Modlin, 1967; Menninger, 1967; Warnes, 1973) have indicated that the traumatic neurosis often includes complaints of impaired concentration and memory.

A study by Leopold and Dillion (1963) in which data were obtained from 34 survivors of a marine explosion offers an excellent example of the traumatic neurosis. The men had all

worked on an oil tanker which had collided with another ship and exploded. The sailors were interviewed two to four weeks after the accident (in 1957) and again, three and one-half to four and one-half years later (in 1960/61). In 1957, 26 of the 34 survivors reported various mood and affect disturbances, such as irritability, nervousness, restlessness, depression, fear, anxiety, startle responses, phobic reactions, and feelings of insecurity; across the 26 men, a total of 33 affect and mood disturbances were reported. In addition, 15 of the survivors reported that they suffered from insomnia and/or nightmares; 12 reported gastrointestinal problems which included gas, pain, belching, bloating, and diarrhea; 11 reported that they suffered somantic problems that included headaches and muscular spasms; and 3 reported that they had problems with concentration and memory. Only six of the survivors indicated that they had no psychological or physical problems.

In 1960/61 the reports of the men indicated that they had gotten worse, not better. Mood and affect disturbances had increased from 37 reported by 26 survivors in 1957 to 73 reported by 33 survivors in 1960/61. There was a marked increase in complaints of restlessness, depression, and phobic reactions. New complaints also appeared: feelings of isolation, of being watched, and of hostility and distrust of co-workers. The sleep disturbances were reported by 22 survivors in 1960/61 as compared to 15 survivors in 1957.

Twenty of the men still complained of gastrointestinal problems and over half of the survivors complained of continuous and sometimes debilitating headaches. In addition, six survivors reported sexual dysfunction and five complained of problems with concentration and memory. One survivor had gone totally blind shortly after the accident, although the authors stated that the mechanism by which this blindness was produced is unclear. It was also noted that whereas in 1957 six survivors reported no psychological complaints, in 1960/61 there was only one such survivor. However, the authors felt that a considerable portion of the one survivor's back disability was psychosomatic in nature.

In addition to producing the above effects, the sea accident also severely disrupted the survivors' ability to function as sailors. Of the 34 survivors, four never returned to sea, 12 returned to sea but were forced to give it up because of psychological difficulties, six returned to sea but worked only sporadically, and 12 of the men returned to sea and worked regularly. All 18 men who continued to work at sea were greatly disturbed emotionally, six of them to the extent that they were unable to work regularly. All 18 of the working sailors reported that they were considerably more tense, anxious, nervous, and fearful aboard ship then on land. The authors also indicated that the greatest incidence of regression of symptoms from 1957 to 1960/61 appeared in the group of men who had returned to sea work. The authors

speculated that this was due to the fact these men were unable to repress the accident because of their continued exposure to salient accident cues.

Leopold and Dillion (1963) also contended that the psychiatric community as a whole has failed to recognize the significance of the nature of the trauma itself, particularly its suddenness, in the development of the traumatic neurosis. The authors stated that it is far more common for clinicians to regard the pre-trauma personality as a major factor, and the accident itself as a set of triggering circumstances for an illness that was almost certain to have occurred anyway. Other writers also feel that the nature of the trauma itself is an important factor in the etiology of the neurosis. Gleser et al. (1981, cited in Bootzin and Acocella, in press) stated that man-made traumas such as torture and rape tend to precipitate more severe reactions than natural traumas such as floods and hurricanes. The authors also added that in the case of natural traumas the greater the threat of death and the larger the population affected, the greater the likelihood that the traumatic neurosis will develop. Bootzin and Acocella (in press) indicated that people who were involved in traumas that resulted in extreme physical peril, loss of family and friends, destruction of homes, and the near obliteration of the social community tend to recover much less quickly than those survivors who can return home to families and accostomed surroundings.

War-related traumas. Several writers (Archibald and Tuddenham, 1965; Bootzin and Acocella, in press; Keiser, 1968) have classified reactions to combat (combat fatigue, shell shock, etc.) and incarceration in concentration and prisoner of war camps as traumatic neurosis. The psychological effects of these experiences can be severe and chronic. The symptoms of combat fatigue can include startle reactions, sleep difficulties, dizziness, black-outs, avoidance of activities similar to combat, depression, fatigue, extreme irritability, difficulty concentrating, nightmares, sighing and yawning, diarrhea, feelings of intense guilt and self-punishment, rage, emotional anesthesia, feelings of alienation, and a lack of trust (Archibald and Tuddenham, 1965; Figely, 1978). Survivors of concentration and prisoner of war camps have been noted to evidence these same symptoms as well as seclusiveness, apathy and helplessness, and paranoid mistrust (Archibald and Tuddenham, 1965; Krystal, 1968; Lifton, 1967, cited in Bootzin and Acocella, in press). It should be noted that the traumas suffered by war veterans and concentration camp survivors were severe and persisted over long periods of time; some of the symptoms could have had physiological bases due to the inhumane treatment that the survivors received.

Similarities Between The Rape Trauma Syndrome and Traumatic Neurosis

The similarities between the traumatic neurosis and the

rape trauma syndrome described by Burgess and Holmstrom (1974) are striking. Both syndromes involve two phases and the symptoms and durations of the acute phases are virtually identical. In addition, the chronic phases of both disorders include some of the same symptoms such as increased fear, depression, anxiety, sleep disturbances, and sexual dysfunction; one survivor in the Brodsky study (1976) and one survivor in the Leopold and Dillion study (1963) went blind after the trauma without any apparent physiological causes. However, it is hard to make direct comparisons between the two chronic phases as the symptoms of the second phase of the rape trauma syndrome are not nearly as well documented as those in the second phase of the traumatic neurosis. Interestingly, researchers in the area of the traumatic neurosis often include rape as a triggering circumstance for the syndrome (Gleser et al., 1981, cited in Bootzin & Acocella, in press; Maudlin, 1967; Menninger, 1967) but only one of the rape researchers cited above (Brodsky, 1976) has made this connection. This oversight could be due, in part, to the reluctance of feminist-oriented researchers to indicate that the rape survivor may be "mentally ill". Unfortunately, this reluctance, however understandable, may act to obscure valuable information that could be used to help the rape survivor avoid this very fate.

In light of the similarities between the traumatic neurosis and the rape trauma syndrome, individuals interested

in the long term effects of rape would do well to utilize the traumatic neurosis literature to acquire new insight into factors which may be related to the rape survivor's adjustment process. For example, Gleser et al. (cited in Bootzin & Acocella, in press) have indicated that reactions to man-made traumas are more severe than reactions to natural traumas; since rape is a man-made trauma it may be fruitful to look to the literature on reactions to these types of traumas to determine factors that are relevant to rape reactions. In addition, Bootzin and Acocella (in press) have noted that reactions to traumas which obliterated the survivors' support system (i. e. by destroying the community) tended to be more severe than the reactions of survivors who could return to families and accustomed surroundings. These data hint that the amount and type of support received by a rape survivor may be germane in differentiating reactions to the event.

Leopold and Dillion (1963) stated that the sailors who developed the most severe symptoms were those who returned to sea employment and hypothesized that this was due to the sailors' inability to repress the accident because of the continued presence of salient accident cues. It is the case that many rape related cues are found in the everyday environments of the survivors such as dark, woods, automobiles, and men who resemble the rapist. Many rape survivors may find it impossible to avoid rape related cues and may, therefore, have the same difficulty repressing the

trauma as the sailors in the above study. The Burgess and Holmstrom (1979b) study that indicated that the ability of the survivor to utilize defense mechanisms was associated with a faster recovery time following rape supports this idea.

In light of the above considerations and research, it might be heuristically valuable to conceptualize reactions to various forms of trauma as a single phenomenon which differs in intensity across individuals and situations. The intensity of a given survivor's raction to a specific trauma would be determined by multiple factors. These factors would include the following: the perceived threat of personal danger, the degree of fear experienced, the duration of the event, the source of the trauma (i.e. natural vs man-made), aspects of the survivor's support system, the ability of the survivor to avoid trauma related cues, and pre-trauma coping skills/personality.

Critique of the Rape Research

Leopold and Dillion (1963) accused the psychiatric community of failing to realize the importance of the traumatic event in the development of the traumatic neurosis and stated that there was a tendency to look for etiological factors in the pre-trauma personality. Through this accusation the authors have implied, but not stated, that the source of this tendency is the psychiatric community's strong trait approach orientation to the study of human behavior and personality. While the rape researchers do not, in general,

ignore the importance of rape related factors in producing the rape trauma syndrome, they do show a propensity to apply a trait approach to the investigation and interpretation of the subsequent adjustment process. For example, many researchers, when attempting to measure the effects of rape, have used self-report measures of personality "traits" such as anxiety, obsessiveness, depression, and compulsion (e.g. Kilpatrick et al., 1979, 1981).

The assumption that underlies this approach to the documentation of rape effects is that rape produces stable, relatively static changes in the survivors' personality (i.e. traits). This approach, which characterizes much of the research on the long-term effects of rape, leads to a tendency to view the rape survivor as "mentally ill" - the possessor of immutable, negative traits - rather then as an individual who is mentally changing/adjusting/coping. It may serve to obfuscate the idea that a woman's reaction to rape is an adjustment process: a process which may produce effects which are dynamic and fluid, effects which may be variable, affecting a survivor at one time but not at another. It is entirely possible that the psychological and emotional problems of the rape survivor are manifested only when rape related cues serve to trigger them. For example, in this view the rape survivor would show an increase in state rather than trait anxiety. The rape studies cited above, which have shown abnormally high scores on trait measures of mood and emotion,

could be used to support this notion as participation in the rape project would serve as a powerful cue to trigger rape related memories and feelings. The Leopold and Dillion study (1963) which indicated that accident survivors had more psychological problems when in the presence of accident related cues would also support this hypothesis.

This trait approach can also produce interpretations of data which lack logical integrity. A particularly compelling example of this can be found in the latest study by Ellis, Atkeson, and Calhoun (1982). The authors compared survivors of repeated rapes (SRRs) to survivors of a single rape (SSRs) and found that the SRR's were significantly more depressed, angry, paranoid, and transient than the SSR's. In addition, the SRR women reported a history of greater utilization of psychiatric services, more suicidal behavior, fewer and less satisfying social relationships, fewer and less satisfying sexual relationships, and lower incomes than the SSR women. Clearly, these differences between SRR and SSR women are exactly what one might predict given that they correspond to the effects of rape documented to date, and one might expect these effects to be magnified by repeated victimization. While the authors did state this possibility (in a single phrase), they quickly added the line, "such a history {of repeated victimization} would exacerbate pre-existing difficulties {prior to any rape}". The authors then go on to imply "trait" differences between SSR and SRR women that may

have in some way contributed to the SRR womens' initial and repeated victimizations. Interestingly, the authors devoted an entire paragragh to this latter possibility.

The Resick et al. (1981) study in which the repeated assessment of rape survivors was shown to be therapeutic points to another problem with much of the rape research done to date. Since many studies in the area involve the repeated testing of a single sample of survivors (e.g. Atkeson et al., 1982; Burgess and Holmstrom, 1974, 1979a, 1979b; Kilpatrick et al., 1979, 1981), the psychological effects of rape documented to date may be distorted or artificially minimized. For example, all of the data reported by Burgess and Holmstrom were obtained from a single sample of rape survivors. These women were interviewed at the hospital directly following the assault, by phone or by home visit weekly for three months, and again at six months, nine months, one year, and four to six years post-assault. The authors stated that crisis counseling was used when needed. If these women developed the problems reported by Burgess and Holmstrom, in spite of the therapeutic effects of repeated assessment, then one can only wonder about the nature and severity of the effects of rape on the survivor who does not have access to these resources.

It was mentioned above that much of the research on the effects of rape is somewhat limited in scope as it has tended to focus on the one to two year period following the assault. In addition, the use of data obtained in this time interval

could obscure the nature of the effects of rape as at least some of the women interviewed may have been in the denial phase of adjustment described by Sutherland and Scherl (1970); a problem which was discussed above in the context of the appropriate studies (Atekson et al., 1982; Kilpatrick et al., 1979, 1981; Resick et al., 1981). The inconsistency between the two studies by Ellis and her colleagues (Atkeson et al., 1982; Ellis et al., 1981) in which longer-term survivors (single assessment) were found to be significantly more depressed than controls, but shorter-term survivors from a later study (repeated assessments) were not found to be more depressed than controls serves to illustrate these problems. There is a paucity of research which has investigated the relatively long-term effects of rape on the survivors' psychological functioning and life style: effects which endure three years or more and might, therefore, be classified as permanent.

In addition, there are several aspects of a woman's adjustment to rape for which the current rape researchers have failed to gather information. First, as previously mentioned, none of the research to date has asked the rape survivor if any positive effects have resulted from the adjustment process. Second, while the rape research has documented post-assault increases in various mood and affective states, and on the occurrence of nightmares, none of the researchers have asked how these factors manifest in the survivor's life

and what effect, if any, they have on the woman's daily functioning and life style. Third, none of the rape researchers have gathered detailed discriptions of the types of responses the survivor has received when she has told others of her experience and about how significant a positive or negative impact these various types of responses have had on her adjustment process. Finally, the research has failed to obtain information on certain attitudinal and background factors which may differentiate patterns of adjustment, such as religious and moral beliefs, the degree to which a woman holds feminist/traditional beliefs, and whether the woman had a rural or urban upbringing.

Purpose of the Current Project

The purpose of the current project was to develop and pilot a semi-structured interview schedule to be used to assess the very long-term effects of rape on the survivors' psychological functioning and life style. Long-term was defined as three or more years post-assault; however, pilot information was taken from any women interested in the project, regardless of the length of the post-assault interval. This information was used to construct items as well as to construct quantifiable response categories for appropriate items. Many items were written to reflect the psychological effects documented in the existing research but were constructed in a fashion which attempted to overcome some of the problems discussed above.

For example, the research participants were asked not only if they had experienced post-assault increases in fear, anxiety, depression, and anger but were also asked how these feelings were expressed, how they affected their daily functioning, and if they were environmentally triggered or more general in nature. If the survivor indicates that the emotional effects are environmentally triggered she was asked to describe, as completely as possible, the salient environmental cues. These same questions were asked in regard to rape-related nightmares and memories (i.e. how they affect daily functioning, how they are triggered).

Items were also designed to determine the coping strategies used most and least successfully by the survivor over the adjustment period. The survivor was also asked to describe the types of reactions that she had received when she has told others about her experience, how significant of an impact she felt that each of the reactions had had on her adjustment, and how positive or negative this impact was. Women who had received counseling for rape related problems were asked to describe the therapy and to indicate whether and why she felt that the therapy was helpful/not helpful. The women were asked if they feel that their adjustment process to the rape had resulted in any positive effects and, if so, to describe the effects.

Items were also included which investigated the social, historical, and cognitive-affective (i.e. attitudes) variables

that may differentiate a survivor's reaction to rape. These variables included urban/rural background, moral convictions prior to the rape, educational and income level, and the type of rape encounter (e.g. degree of fear experienced, duration, number of assailants involved, degree of violence, etc.). The survivor was also asked to describe any lifestyle changes that she felt resulted from the assault and the degree to which the assault had restricted her current life (e.g. need to live with someone, inability to take certain jobs, decreased enjoyment of pre-rape activities, etc.).

The completed instrument, called the Rape Assessment Schedule (RAS; see appendix A), includes both quantitative and qualitative items; the former include some Likert scale items as well as some items for which codable response categories have been supplied by the pilot data.

Method

Initial Form of Rape Assessment Schedule

The initial form of the Rape Assessment Schedule (RAS) represented a synthesis of information from several sources; 1) the current literature on the effects of rape on the survivor and the literature on "traumatic neurosis", 2) a semi-structured follow-up interview developed by Ellis, Atkenson and Calhoun (1981) and 3) the ideas of a small group of long-term rape survivors who were acquaintances of the experimenter.

Current literature. The current rape literature provided

essential information concerning the effects of rape on which a portion of the initial questions were based. These items included those which concerned emotional changes, the occurrence of nightmares, changes in interpersonal relationships, possible restrictions in employment and housing, the pursuit and enjoyment of daily activities, sexual functioning, factual information about the rape event and relevant demographic data. In addition, the items outlined in the purpose section above were included; items which attempted to overcome some of the shortcomings in the rape research, and items suggested by the traumatic neurosis literature.

Ellis, Atkinson and Calhoun. A copy of the semi-structured interview used by Ellis, Atkinson and Calhoun in their 1981 study was obtained from the authors. Only a few questions that pertained to demographic data were taken directly from the interview. However, this interview suggested the inclusion of items that measured changes in the survivor's physical health and alcohol and drug use.

Long-term rape survivors. A group of five long-term rape survivors, who were acquaintances of the experimenter, were contacted and asked to participate in the research. The five women were asked to discuss the general question, "Do you feel that your rape experience produced any enduring changes in your thoughts, feelings, behavior and general lifestyle?". The researcher took notes of these proceedings and the information was used to generate additional items for the RAS;

the women were fully informed that their responses were used in this fashion. The women were encouraged to contact the current investigator if they thought of any additional relevant information.

Synthesis. The next step in the development of the RAS involved a synthesis and integration of the information from the three areas described above. This process resulted in a 72 item questionnaire. The majority of these items were open-ended in form, although approximately one-third of the items (31%) contained loosely structured response categories or 5-point likert response scales. After completion, this form of the RAS was used to begin the three stage piloting/revision process that will be described below.

Research Participants

Participants. The following demographic data pertains to 19 survivors who responded to one of the three developmental forms of the RAS; the five women who contributed to the development of the initial form of the RAS are excluded due to a failure to obtain and record the complete demographic information.

The sample consisted of 19 adult Caucasian women. The mean age of the women at the time of the interview was 27.5 years (range = 19-50 years); the mean age at the time of the assault was 20.1 years (range = 16-24 years). The mean income for the sample at the time of the assault was $5,400 a year; the current mean income was $22,625 a year. In addition, 63%

of the sample indicated that they came from a rural background while 37% indicated an urban background.

The mean post-assault interval (i.e. time between rape and the present) was 7.72 years (range = 1.5-34 years). However, the post-assault interval of one of the survivors was 34 years; the mean interval excluding this extreme score was equal to 6.17 years (range = 1.5-14 years). Fifty percent of the sample had been raped by strangers and 50% had been raped by acquaintances. Seventy-seven percent of the sample had been raped by a single assailant and 23% had been raped by multiple assailants. In terms of the location of the rape, 33% of the women had been raped in either their own or a friend's/relative's home, 44% had been raped on public ground, and 23% had been raped at other locations such as the rapist's home or a car.

Recruitment of survivors. Rape survivors were primarily recruited in one of two fashions: 1) Through the use of advertising and media presentations, and 2) Presentation made by the researcher to local women's groups and students in classes at Kansas State University. In community and town/city newspapers, the reseacher requested feature stories regarding the study. Flyers with a general description of the research were also posted in the Manhattan area and on the local military base. Flyers were placed is such locations as supermarkets, laundromats, social service agencies, community centers, and public service facilities.

Presentations made by the researcher covered what is known about the long-term effects of rape and described the project and its aims. Presenters emphasized that little is known about the long-term effects of rape, in part because many women do not admit to an assault in fear of the reactions of others. The researcher also attempted to validate each survivor's reaction to the assault and to reassure all survivors that their reactions were/are justifiable. In order to do this, it was noted that prior to the advent of rape crisis centers, hot-lines, counseling services, etc., rape survivors were neglected by both researchers and counselors. It was stated that women were not likely to share their experiences because there was no one visible with whom to do this. The presenter stressed that it was and is common for women to blame themselves for their assault and subsequently not see "their problems" as legitimate concerns for others. It was also mentioned that it is common for rape survivors who do tell their stories to receive negative reactions that include disgust, disbelief, ridicule and pity regarding their new "damaged" status. It was hoped that such attempts to validate the rape survivor's fear of sharing her experience would help to form a basis on which to construct a trusting relationship in which the survivor felt comfortable enough to discuss her experience candidly.

It was originally proposed that only data from survivors who had experienced a rape three or more years prior to

participation would be included in the analyses, although all women who contacted the researchers would be interviewed. However, during the course of the interviews it was noted that there was a remarkable similarity of effects across the various post-assault intervals. Therefore, data was included from all survivors interviewed; two survivors had post-assault intervals in the one-two year range, 4 women had post-assault intervals in the 2-3 year range and all other survivors had post-assault intervals of three years or greater. It was also proposed that survivors of marital rape be excluded from the analyses. This criterion was abandoned for the same reason as the post-assault interval criterion; one survivor of marital rape participated in the study.

Selection biases. Previous research has suggested that survivors of rape can be characterized as experiencing phases of adjustment regarding the assault. Of relevance to this project is the denial and apparent recovery phase described by Sutherland and Scherl (1970) and the reorganizational phase described by Burgess and Holmstrom (1974). Both phases involve a time period, of varying length, during which the survivor may suppress any reactions to the rape experience. She may, for example, be viewing television when a program depicting rape is aired and change the channel without having ever connected that reaction to the program with her rape experience. Obviously, the survivor coping with her experience in this manner was less likely to respond to

recruitment to a study of this nature. This may have effectively eliminated a category of adaptational style. Moreover, some rape survivors will not/can not talk about their experience, even though they have an awareness of it, and, therefore, will not participate in a project of this nature. These are limitations that could not be overcome.

In addition, it might be argued that women who volunteered to participate in the current research project were those survivors who had had the most difficulty adjusting to their rapes. Logically, it is impossible to state conclusively that the current sample was comprised solely of women who had experienced the most severe effects or solely of women who had experienced more positive reactions. It is the case that these women were able to overcome a tendency to avoid a situation that was reminiscent of their assault. Many of the survivors indicated that it had been very difficult for them to come forward to be interviewed and that, until the very last moment, they were unsure that they could keep the appointment. Yet they came, and the majority indicated that they were motivated to do so because of a desire to help other women. Why these women were able to overcome their avoidance tendencies while other survivors can not/did not and the implications that this has on the interpretation of the present findings is a matter of speculation.

Potential risks to participants. Potential psychological risks for the research participants included increased

anxiety, fears, depression and nightmares caused by recalling their assault. In order to safeguard research participants against these psychological risks, counseling was offered through the Regional Crisis Center (RCC, available on a 24 hour basis). The researchers' telephone numbers were also provided and the survivors were encouraged to call, regardless of the time, if they became distressed. All interviewers participated in a workshop given by the RCC staff which will be described below. In addition, crisis counseling was provided as needed during the interview. The researcher also offered to contact the research participant after the interview to again assess the participant's emotional state. None of the participants requested or apparently required any post-interview counseling. An assessment of the survivors' emotional state at the end of the sesssion indicated that all of the women felt more positive on leaving the research situation then they had upon arrival.

In addition, subjects' confidentiality was guaranteed. Consent forms and questionnaires were coded in such a way as to protect the research participants' anonymity. Names and identification numbers are kept in a locked file and will be available only to the researchers for three years. After this time the file will be destroyed. All data will be presented and/or published as a whole; no individuals will be identified.

Potential benefits to participants. It has been

suggested (Atkinson et al.,1982) that the interviewing process has a therapeutic effect on rape survivors. Therefore it was assumed that the research participants might benefit from the chance to recall the assault in a supportive environment and work through any negative feelings that arose. For the women in the current sample this notion seemed to be correct. Many of the survivors appeared to be energized by the interview and spontaneously expressed positive feelings to the researcher. Many felt relieved because they realized that they were no longer alone and that their reactions were not unusual or crazy. For some of the survivors the research situation offered the first validation and support that they had received for their adjustment experiences. Many of the survivors expressed a desire to continue to share their experiences; therefore, the researchers, in conjunction with Kansas State University's Women Resource Center, established a rape support group to offer the research participants a chance to continue sharing in a supportive environment.

Research procedures

Physical environment. All participants were given the option of data collection occurring in their homes or at the Psychology Department of Kansas State University. Research space at the university was equipped with a comfortable sofa and warm lighting. This space was also equipped with a tape recorder which was in full view of the research participant and was addressed in the informed consent protocol.

Entry protocol. At this time the participant was again provided with a general description of the nature and purposes of this research. Rape survivors were informed of the following by the researcher who conducted the interview:

a. An explanation of the nature and purposes of the research;

b. A description of the interview and the type of information solicited;

c. A description of the possible therapeutic benefits of the interview to the research participant;

d. A description of the possible negative side effects of the interview on the individual. Specifically, it was stated that these might include increased anxiety, fears, depression and nightmares stimulated by recalling the assault;

e. An explanation of the resources available to participants who wanted to discuss their experience further after the interview;

f. A statement insuring the confidentiality of the interview;

g. An explanation of whom to contact after the interview for any further questions or additional information;

h. An explanation of the participant's right to withdraw consent at any time during or after the interview and her right to have her records destroyed without any penalty.

There was no deception involved in this study. No information was withheld from the research participants; all questions were answered fully before, during and after the interview.

Interview. The interviews were conducted either by the author or by a trained female interviewer. All interviewers participated in a workshop given by the Regional Crisis Center (RCC) staff and professionals associated with the center. Such training included instruction in non-judgmental and supportive counseling techniques by which to develop rapport with the research participants. Training also increased the sensitization of the interviewer to possible emotional reactions of the survivor and the proper way to handle these should they arise. This workshop was designed for anyone who works with survivors of domenstic violence or survivors of rape.

At the beginning of each interview the experimenter stressed that she was not only interested in the participant's response to each item but was also interested in any relevent feedback concerning item appropriateness and clarity that the participant might have. The participant was also asked to indicate if she felt the questions as a whole reflected her experience or if she felt certain areas had been neglected. The researcher kept note of all relevant comments regarding these issues. The interviewer read all items to the participants and took detailed notes of the participants

open-ended response. In addition, after giving a free response, participants were allowed to review and check response categories and mark scales on appropriate items. The researcher kept note of open-ended versus cued responses on these items. The interviews were untimed and took an average of two and one-half hours to complete.

Exit protocol. After completion of the interview any questions regarding the previous procedures were answered. In addition, the researcher took time to talk casually with the participant so as to assess the survivor's emotional state and to give the women time to reorient to the daily environment.

Pilot/Revision Process

The initial form of the RAS (see above) underwent three stages of piloting/revision before the final form of the questionnaire was completed. The schedule was administered to a small group of long-term rape survivors at each stage of the process. A general description of the revision strategy is given below. This is followed by a discussion of the participants utilized and the issues confronted within each stage of the piloting/revision process.

Revision strategy. During the interviews the researcher recorded all responses by hand and also taped the proceedings. The tapes were to be used after the interview to check the accuracy of the written information. Unfortunately, due to a malfunctioning of the recording equipment, the majority of the

interview tapes were incomprehensible. Immediately following each research session, the researcher who had conducted the interview carefully reviewed the written interview transcript to insure that all recorded responses were clear and legible.

At the end of each piloting/revision stage, the associated interview transcripts were read independently by at least two researchers involved with the project. Each researcher compiled a list of response themes which occurred for each item and recorded the number of participants who indicated each theme. The researcher also kept note of all relevant participant feedback which concerned the clarity and appropriateness of the items. The researchers then met to discuss the above information. On the basis of this process the RAS was revised; response categories were generated that reflected the women's answers, and items were revised, deleted or constructed.

The RAS underwent the above process three times before the final form of the questionnaire was completed. Many of the changes involved the rewording of questions to reflect a less academic vernacular, and the deletion of items that could not be answered or which seemed to produce redundant or low utility information. However, some of the changes involved additions to the content area of the questionnaire which were suggested by various aspects of the revision process; these content changes and issues will be discussed below.

Stage One

Participants. Eight long-term survivors responded to the initial form of the RAS. The mean post-assault interval was 5.8 years. The mean age at the time of the assault was 18.8 years; the mean age at the time of the interview was 24.6 years.

Revisions. The survivors involved in the first stage of piloting/revision suggested several content areas which they felt had been neglected on the initial form of the RAS. The first of these areas concerned the effect that a rape related pregnancy might have on a woman's adjustment to a rape. One survivor stated that she felt that an abortion she had had following a rape had been more traumatic and had caused her more psychological difficulties then the rape itself. A second issue concerned the effect that certain moral convictions, such as a strong belief in virginity before marriage, might have upon the adjustment process. It was also pointed out that a rape could also affect changes in the nature of moral convictions held at the time of the assault; changes which might indirectly effect the woman's adjustment. Since the researchers felt that these dimensions might serve to differentiate womens' reactions to rape, items were added to the RAS in an attempt to tap these factors.

In addition, while the women were asked to define vulnerability and to indicate how often they felt vulnerable, they were not asked about strategies used to reduce/control these feelings. Several of the survivors pointed out that

these strategies were extremely important to their adjustment and therefore, questions were added which assessed these strategies and their effectiveness. Furthermore, one survivor stated that she felt that an extremely negative reaction that she had received from the police had caused her to have additional adjustment problems. It was then decided that information which regarded a survivor's police and/or court experiences and the effect that these experiences had had on her adjustment should be gathered.

Another content addition made at this stage of the revison process was suggested in a presentation attended by the author (West and Hughes, 1983). The presentation concerned a detailed study of the effects that various support system reactions had on the rape survivor's adjustment. West stated that certain positive-negative reactions given by important members of the survivor's support system could have a profound influence on the course of a survivor's reaction to rape. Therefore, an entire section was added to the RAS which concerned specific support system reactions, the significance of these reactions to the survivors, and the magnitude of their positive-negative effect on the survivor's adjustment. The reactions included in this section were congruent with those described by West and Hughes.

Another change involved an item on the questionnaire designed to tap changes in interpersonal response style which might follow a rape. The original item asked the respondent

about changes in interpersonal response style in relation to five categories of individuals; female friends, male friends, females (in general), males (in general) and, coworkers. Because of an apparent lack of differentiation in participant response across these five categories the item was restructured to include only the two general categories, females and males.

Stage Two

Participants. Four long-term survivors of rape responded to the revised form of the RAS (form two). The mean post-assault interval was 2.25 years. the mean age at the time of the assault was 22.7 years; the mean age at the time of the interview was 24.6 years.

Revisions. Although the mean post assault interval was rather low on this subsample of participants, the researcher decided to revise the RAS based on this data as some flagrant problems were discovered with the form two questionnaire. One of the more serious of these problems concerned a failure to ask any questions in regard to a previous history of sexual assault. During the course of an interview one survivor stated that it was very hard for her to separate the effects of her rape from the effects of an earlier experience of incest. This information would not have come to light if this survivor had not spontaneuosly mentioned the incest incident. If a history of repeated victimization exacerbates the psychological effects of rape, as suggested by the 1983

article by Ellis et al., then it is vital that a sexual assault history be taken.

Another problem which was corrected at this stage of the piloting/revision process concerned a heterosexist bias held by the researcher. In the item which regarded changes in interpersonal response style towards women and men, questions were asked that concerned changes in flirting/dating behavior in response to males; these questions were not asked in regard to females. A lesbian participant mentioned that she could answer the questions if the referent was changed from male to female: the item was again restructured so that identical questions were asked in regard to both sexes. This provides a particularly striking example of the value of utilizing participant feedback to correct personal bias in research.

A final addition to the RAS was suggested by an intuitive observation made by the researcher. It seemed that the survivors who reported the most difficulties were those women who had experienced the most profound sense of a loss of control over their personal safety/security. For example, one of these survivors had taught self-defense and rape prevention at the time of her assault. Because of these skills she had felt totally prepared for and able to prevent an attack. When this survivor was attacked she had fought to the best of her abilities and she had lost; both that battle and all of her faith in her competency to avoid future assault. Subsequently, she felt that she had lost all control over her

personal safety/security and did not feel that she could do anything to regain this mastery. It seemed logical that survivors who report a greater decrease in the amount of control they have over their safety/security following a rape might show more negative effects; therefore an item was added to the RAS in an attempt to measure this change.

Stage three

Participants. Seven long-term survivors of rape responded to this form of the RAS (form three). The mean post-assault interval was 13.8 years. However, this subsample included the 34 year survivor mentioned earlier; the mean post-assault interval excluding this extreme score was 9.8 years. The mean age at the time of the assault was 17.7 years; mean age at time of interview was 27.5 years.

Revisions. By this stage in the piloting/revision process all changes which involved content had been made. Feedback from the participants in the final sample indicated that the RAS accurately reflected their experiences as rape survivors. At this point the majority of the revisions involved a finalization of the response categories and scales for the items and the formulation of data coding strategies. The final form of the RAS (see appendix A) contained 129 items and usually requires two and one-half hours to administer.

Final Comments

During the analyses of the pilot data from the current project an additional problem was discovered with the item

designed to assess changes in interpersonal response style to females and males. As mentioned, the item had been restructured to ask about changes in response to two general categories, females and males. Upon data interpretation, the author decided that the information which regarded changes in interpersonal response to female and male friends-two categories which had been deleted earlier- was needed for a more complete understanding of this issue. Therefore, the item was again restructured to include response categories for male and female friends as well as for females and males, in general.

Since completion of the current project, a research project has been started in which the RAS is being used to assess the long-term effects of rape. During the construction of a form of the RAS to be used with a control group of non-victimized individuals, an additional problem with the questionnaire was discovered. On a number of items which deal with changes in emotional levels the women were asked to indicate if various stimuli triggered a given emotion (see item 93, appendix A, for example). The researchers felt that control women might be just as likely as the survivors to indicate an emotional response to these stimuli and that what might differ across these women is the intensity of the response. Therefore all items of this nature were scaled so that the respondents could indicate both if a given stimuli triggered an emotional response and the intensity of that

response.

In addition, during the first interview which utilized the RAS, the survivor indicated that she had attempted suicide following the assault. Since a suicide attempt might be indicative of a more severe reaction to the assault an item was added to the questionnaire to measure post-assault changes in suicidal tendencies. The RAS is now being used in research. It is anticipated that minor revisions will continue to occur in response to feedback from administrations.

Analysis

Data Coding and Inter-judge Agreement

Upon completion of the RAS, data from all 19 respondents were coded according to the final format of the questionnaire. Some items remained constant over all forms of the questionnaire and data coding was relatively straight forward. Other items were added at later stages of development; in regard to some of these items, the necessary information was given in other sections of the earlier form of the RAS and was extrapolated by the coder. In regard to the remainder of these items, the necessary information was not given and the data were coded as missing. All items were coded independently by at least two trained judges; this process resulted in two complete sets of coded data.

Inter-judge agreement was then computed on a subset of the

coded items. Forty-five items were chosen which involved the most judgment/extrapolation on the part of the coders. The number of times coders agreed across response categories was divided by the total number of possible agreements for each item. Across items, inter-judge agreement was .70; within items, agreement ranged from .45 to .94. I then noted that one of the judges apparently had difficulty with the application of the coding criterion which resulted in an unusually high number of coding errors. I, therefore, independently recoded this individual's data and recalculated the inter-judge agreement. My agreement with another judge was .83 (range .52 to 1.00). This latter data set was then summerized and used in the subsequent interpretation/discussion.

In addition, a rough estimate of the inter-judge agreement for the final form of the RAS was calculated. To do this three trained judges listened to a single taped interview which utilized the final questionnaire form. The judges then coded the data independently and inter-judge agreement was calculated on all possible pairs of the three data sets. All items were included in these computations. This resulted in three inter-judge agreement coeffecients (.87, .89, & .86) which were then averaged to produce a single coeffecient for the final form of the RAS. This value was .88.

Results And Discussion

There were several theoretical issues and problems with

regard to the current literature on the psychological effects of rape which the present interview schedule (i.e. the RAS) was designed to investigate. What follows is not an exhaustive account of the pilot data but rather concentrates on data relevant to these issues/problems. The areas to be discussed include:

1. the documentation of longer-term effects of rape (3 or more years);

2. the degree to which the psychological and emotional problems of the survivor are trait-like vs. cued;

3. how the effects of rape are manifested in the survivors' life;

4. what factors the survivors state have been germane to their adjustment;

5. and whether the survivors feel any positive effects have accrued from the adjustment process and, if so, the nature of these latter effects.

The data that are pertinent to these issues are listed below. It should be noted that the size of the sample of respondents varies across questions. Number of respondents varies because some of the items were added to the questionnaire in later phases of development; other items were not applicable to all participants.

Data Summary Table

Note. Listed below are paraphrases of items and response categories from the final form of the RAS; the RAS item numbers corresponding to each paraphrase are given. Values preceding categories represent the proportion of women who

indicated that response; sample size is indicated for each item.

I. Cueing Issue

1a. Occurrence of nightmares (n = 19; RAS item 82)
.78 yes
.15 no
.07 had at one time but no longer

frequency of occurrence (RAS item 83)
.00 often, at least once a week
.68 several times a month
.00 once a month
.33 several times a year
.00 seldom, no more then once a year
.27 rarely, but occasionally
.00 never
.33 it varies

b. What cues nightmares (RAS item 84)
.53 general rape cues
.26 unsure
.26 feelings of vulnerability
.20 cues specific to woman's rape
.13 battering, sexual violence

2a. Occurrence of memories (n = 19; RAS item 87)
frequency of occurrence
.26 often, at least once a week
.05 several times a month
.05 once a month
.05 several times a year
.00 seldom, no more than once a year
.44 rarely, but occassionally
.00 never
.36 it varies

b. What cues memories (RAS item 88)
.63 cues specific to the woman's rape
.57 restimulation of memory of any event occurring around time of assault
.57 rape and sexual violence
.46 idiosyncratic response (i.e. the smell of alcohol
.36 feelings of vulnerability
.16 unsure

3a. Anger (n = 19; RAS item 91))
.89 have experienced a change in level
.11 have not experienced a change in level

Degree of change rated on a 7-point scale; 1 = much

less & 7 = much more anger
M = 6.3
range = 2-7

b. What cues anger (n = 19); RAS item 93)
.47 rape, sexual violence
.47 male dominance and arrogance
.47 physical abuse of women by men
.41 specific, idiosyncratic responses (i.e. pornography)
.35 lack of respect of women by men
.29 male ignorance
.29 women who refuse to take rape seriously
.17 verbal abuse of women by men
.17 woman putting themselves in dangerous positions
.10 lack of compassion for rape victims, bystander apathy

c. Is the emotion specific or general in nature (n = 19; RAS item 92)
.88 specific
.06 general
.06 both, at different times

4a. Anxiety (n = 17; RAS item 98)
.82 have experienced a change in the emotion
.18 have not experienced a change in the emotion

Degree of change rated on a 7-point scale; 1 = much less & 7 = much more anxiety
M = 5.5
range = 3-7

b. What cues anxiety (n = 12; RAS item 100)
.58 being alone
.42 cues specific to woman's rape
.42 general rape cues
.42 feelings of vulnerability
.33 other specific, idiosyncratic responses (i.e. cat calls)
.16 unsure

c. Is emotion specific or general in nature (n = 12; RAS item 99)
.67 specific
.25 general
.08 both at different times

5a. Fear (n = 17; RAS item 104)
1.00 have experienced a change if the emotion
.00 have not experienced a change in the emotion

Degree of change rated on a 7-point scale; 1 = much less & 7 = much more fear
M = 6.65
range = 1-7

b. What cues fear (n = 16; RAS item 106)
1.00 dark, being alone, and strangers
.43 cues specific to woman's rape
.43 feelings of vulnerability
.19 general rape cues
.13 exsistence of rape myths
.13 other specific, idiosyncratic responses (i.e. rapist return)

c. Is the emotion specific or general in nature (n = 17; RAS item 105)
.65 specific
.18 general
.18 both at different times

6a. Depression (n = 18; RAS item 112)
.61 have experienced a change in the emotion
.39 have not experienced a change in the emotion

Degree of change rated on a 7-point scale; 1 = much less & 7 = much more depression
M = 4.3
range = 1-7

b. What cues depression (n = 6; RAS item 114)
.33 general state of the world
.33 feelings of hopelessness
.33 other specific, idiosyncratic response (i.e. legal system)
.16 over changes in life produced by rape

c. Is the emotion specific or general in nature (n = 6; RAS item 113)
.50 specific
.50 general
.00 both at different times

7. Vulnerability (n = 11)

a. How defined, "what makes you feel that way" (RAS item 118)
.68 when not in control of the situation
.42 situation were an assualt likely
.37 being alone
.32 other specific, idiosyncratic response (i.e. when ever feel emotionally close with others)
.21 strange (unknown) men

.26 when physically unable to protect self
.05 new situations

b. How often feel vulnerable (n = 11; RAS item 119)
.10 all of the time
.18 several times a day
.27 often/fairly often
.18 several times a month
.18 seldom/rarely
.10 varies

c. Change in tendency to notice vulnerability cues (n = 19; RAS item 120)

Rated on a 7-point scale; 1 = no change & 7 = large increase
M = 5.98
range = 4-7

II. Effects on Functioning

8. Nightmares

a. Degree of disruption (n = 14; RAS item 85)
.00 not at all disruptive
.57 mildly disruptive (causes tension, unpleasant feelings)
.21 moderately disruptive (causes difficulty on the job, lack of concentration, etc)
.07 severely disruptive (miss work, stay home, etc.)
.14 degree of disruption varies as a function of the dream

b. Nature of the disruption (n = 14; RAS item 86)
.53 specific, idiosyncratic responses (i.e. flashbacks)
.33 withdrawn
.20 inability to concentrate
.13 numbness, no emotion
.13 jumpy, tense and irritable
.13 inability to function
.06 tierd, lethargy

9. Memories

a. Degree of disruption (n = 17; RAS item 89)
.18 not at all disruptive
.54 mildly disruptive (causes tension, unpleasant feelings)
.18 moderately disruptive (causes difficulty on the job, lack of concentration etc.)

.00 severely disruptive
.05 degree of disruption varies as a function of the situation

b. Nature of disruption (n = 17; RAS item 90)
.31 inability to concentrate
.26 extreme fear
.21 specific, idiosyncratic responses (i.e. startles)
.16 withdrawn
.15 physiological symptoms
.10 numb, no emotions
.10 inability to function adequetly
.05 totally non-functional

10. Anger

a. Degree of disruption (n = 15; RAS item 95)

Rated on 7 = point scale; 1 = not at all & 7 = extrememly disruptive
M = 4.33
range = 1-7

b. How anger is expressed (n = 17; RAS item 94)
.41 no overt response, tight and tense
.35 rage, tantrums
.35 other specific, idiosyncratic responses (i.e. it varies, etc.)
.29 shake, cry
.29 verbally address source of anger
.17 feel heavily burdened by anger
.12 attempt to be very rational
.06 self-abuse

c. Nature of disruptions (n = 14; RAS item 96)
.50 upsets family
.50 can't be alone
.25 anger inappropriate in some situation, causes trouble (i.e. at boss, etc.)
.25 become physically ill

11. Anxiety

a. Degree of disruption (n = 12; RAS item 101)

Rated on 7 = point scale; 1 = not at all & 7 = extremely disruptive
M = 4.03
range = 1-7

b. Nature of disruption (n = 12; RAS item 102)
.45 difficulty being alone

.33 specific, idiosyncratic responses (i.e. causes problems with friends, etc.
.23 avoids or is uncomfortable in new situations
.23 jumpy, nervous or tense
.12 difficulty concentrating
.12 totally non-functional

12. Fear

a. Degree of disruption (n = 19; RAS item 108)

Rated on 7-point scale; 1 = not at all & 7 = extremely disruptive
M = 5.1
range = 1-7

b. How fear is expressed (n = 19; RAS item 107)
.58 instrumental response to reduce fear (i.e. call friend, etc.)
.47 physiological, autonomic responses (i.e. heart pounding, etc.)
.41 hyper cautious
.35 freezes, panic
.29 cry, hysterics
.29 other specific, idiosyncratic responses (i.e. trys to accept and control fear, etc.)
.06 difficulty functioning
.06 trys to act very tough
.06 totally non-functional

c. Nature of disruptions (n = 19; RAS item 109)
.58 restricts activities, life
.33 other specific, idiosyncratic responses (i.e. makes do rash things, etc.)
.17 upsets family
.17 difficulty functioning adequetly
.08 withdrawn
.08 jumpy, irritable
.08 yells, argumentative

13. Depression

a. Degree of disruption (n = 6; RAS item 115)

Rated on 7-point scale; 1 = not at all & 7 = extremely disruptive
M = 4.14
range = 1-7

b. Nature of disruption (n = 6; RAS item 116)
.75 specific, idiosyncratic responses (i.e. argumentative, loneliness etc.)

.25 difficulty functioning adequetly
.25 difficulty concentrating
.25 low energy, lethargy
.25 easily frustrated

III. Life/Living restrictions

14. Changes in living arrangements (n = 19; RAS item 39)
.68 various safety pecautions (i.e. locks, bars on windows etc.)
.47 the need to have roommates
.42 other (booby traps, phones in all rooms etc.)
.37 need to know neighbors
.31 need to have dog
.31 second story access to living quarters
.10 no changes

15. Changes in style of living (n = 10; RAS items 40, 41)
.80 no longer walk alone at night
.60 began to carry a weapon
.60 no longer engage in activities alone
.60 other specific, idiosyncratic responses (i.e. openly confronts men who are following or acting suspicious, etc.)
.50 no longer drive alone at night
.40 learned self-defense
.10 no longer drive alone during the day

16. Changes in general feelings of security when at home (n = 19; RAS item 42)
rated on 7-point scales; 1 = very & 7 = not at all secure

security at night
M before rape = 1.6
M after rape = 4.36

security in day
M before rape = 1
M after rape = 2.26

17. Job restrictions, jobs might have taken prior to the assault but will no longer consider (RAS item 46)
.53 any job at night
.47 any job where safety precautions are a potential concern (i.e. working alone or in a rough neighborhood)
.24 any job which was reminiscent of the assualt (i.e. doing social work now if female social worker who had been assaulted while on a case)

.19 any job which required a high degree of contact with men (i.e. at a truck stop or as a barber)
.06 any job in which a man or men had power over survivor (i.e. as a secretary for male employer)

IV. Changes in Relational Style

19. Sexual problems (n = 19; RAS item 35)
.73 have had some problems since the assault
.15 have had no problems
.11 not applicable
.63 still experiences problems

20. Relational style (n = 12; RAS item 36)
.33 much more selective about men
.27 increased distance to men
.22 other specific, idiosyncratic responses (i.e. can not trust etc.)
.16 have to control sexual encounters, initiate acts etc.
.16 changed or facilitated change of sexual preference

21. Did the way individual's reacted to the survivor change her relationships with those individuals. (n = 19; RAS item 57)
.78 yes, reactions affected relationships
.22 no, reactions did not change relationships

What was nature of this effect (n = 15)
.60 if individual reacted positively, then survivor became close to the individual
.66 if individual reacted negatively, then survivor became more distant with the individual

22. Changes in inter-personal responses to women and to men, in general, since the assault. (n = 19; RAS item 59

women	men	
.00	.15	don't date women (men) any more
.00	.21	date women (men) only if know well
.10	.21	not as open with women (men)
.15	.10	lost some female (male) friends due to assault
.15	.00	closer to women (men) then used to be
.57	.10	form stronger bonds with women (men)
.47	.00	trust women (men) more
.78	.00	empathize more with women (men)
.31	.00	have more female (male) friends
.05	.36	do not make new female (male) friends

		as easily
.05	.84	uncomfortable with women (men) don't know well
.05	.31	uncomfortable with women (men) in general
.10	.89	more suspicious of women (men)
.10	.78	avoids women (men) that don't know well
.57	.05	avoids being alone with women (men) don't know well
.00	.57	won't talk to women (men) don't know well
.00	.21	difficulty working with women (men)
.05	.58	feels threatened by women (men) with power over her
.00	.00	no change in inter-personal response

23. Changes made to discourage men from approaching (n = 19; RAS item 125)
    - .68 made changes
    - .32 did not make changes

    Nature of changes
    - .62 altered physical appearance (i.e. gained weight, stopped dressing up etc.)
    - .62 changed inter-personal strstegies (i.e. acted less friendly etc.)

III. Adjustment

24. Reactions received from others which aided positive adjustment (n = 19; RAS item 54)
    - .94 non-judgmental, accepting, did not blame
    - .82 allowed to express emotions
    - .76 gave the survivor someone to talk to
    - .58 helped assure the survivor's feelings of physical safety (i.e. stayed with survivors, etc.)

25. Positive effects which resulted from the adjustment process (n = 11; RAS item 129)
    - .90 experienced some positive effects
    - .10 did not experience any positive effects

    Nature of the effects (n = 10)
    - .27 able to help other women
    - .27 increased awareness of women's rights
    - .27 became more careful and cautious
    - .27 know that able to survive
    - .27 increased sense of psychological strength
    - .09 changed sense of priorities; learned what is important

26. Prescriptions to recent survivors (n = 19; RAS item 128)
    .63 get support/help
    .47 other specific, idiosyncratic responses (i.e. talk to feminist etc.)
    .21 don't take blame
    .16 don't withdraw

Discussion of Results

The results of this pilot investigation indicated that the effects of rape on a woman's psychological functioning and life style can endure for years. Of the 19 survivors who responded to the RAS (mean post assault interval = 7.72 years) all reported some enduring changes in functioning and life-style. In general, these effects paralleled the shorter-term effects of rape documented in the psychological literature. These included the occurrence of nightmares and intrusive, rape-related memories, changes in levels of fear, anxiety, anger and depression, sexual dysfunction and various life restrictions. In light of the findings of this investigation, it can be concluded that, for some women, the psychological and social changes which follow a rape may be considered relatively permanent.

Emotional functioning. Participants were asked a series of questions which tapped changes in levels of anger, fear, anxiety and depression since the assault. The mean change scores for the group of respondents indicated a general tendency to show increases in the levels of all four emotions. The greatest increase was associated with fear and the least

with depression (see Table, items 3a, 4a, 5a, & 6a). It is interesting to note that in regard to the emotions of anger, anxiety and depression, at least some of the women (n=1, 2 and 8, respectively) indicated a decrease in the manifestation of the emotion; with regard to fear, however, 100% of the sample indicated an increase. In addition, 76% of the women indicated an increase in the manifestation of anxiety, 66% an increase in anger, and 33% an increase in depression. In general, these findings are congruent with the conclusion of Kilpatrick and his colleagues (Kilpatrick, et al., 1981) that fear and anxiety may represent long-term problems for the survivor.

State-trait issue. Many of the researchers in the area of rape show a propensity to apply a trait approach to the investigation and interpretation of the effects of rape on women. This approach is reflected by the use of trait measures of moods and emotion; measures most commonly used to assess psychopathology in clinical populations. It was argued that this approach may serve to obfuscate the view of a woman's reaction to rape as an adjustment process which may result in effects which are variable, affecting a survivor at one time but not another. Within this view, it is entirely possible that the psychological and emotional problems of the survivor are manifested only when rape related cues serve to trigger them; that is, that the survivor experiences state rather than trait changes in emotional functioning. The pilot

data from the current investigation offered support for this latter view.

After they had responded to each question which tapped changes in emotional levels, those survivors who indicated an increase were then asked if they felt that these emotions were aroused under specific conditions (i.e. state-like) or were more general (i.e. trait-like) in nature (see Table, items 3c, 4c, 5c, & 6c). It was also possible for the woman to indicate that the emotion seemed both general and specific at different times. In addition, these survivors were asked to describe events which were related to feeling a given emotion (see Table, items 3b, 4b, 5b, & 6b).

In response to all of the emotions except depression, the majority of the women indicated that the emotion was aroused under specific environmental conditions rather then being general in nature. This finding was strongest for anger (88% specific, 5.8% general, 5..8% variable) and least strong for fear (64% specific, 17.5% general, 17.5% variable) and anxiety (67% specific, 25% general, 8% variable). The data indicated that the pattern of environmental cues that served to trigger fear and anxiety were remarkably similar while those associated with anger and depression showed unique patterns. With respect to anxiety and fear, those cues most frequently indicated by women were either directly rape related (i.e. cues specific to her rape or to rape in general) or can be conceptualized as rape related. These latter cues regarded

potential victimization (i.e. feelings of vulnerability, dark, alone, etc.). In general, the majority of cues mentioned by the survivors in response to fear and anxiety fell in this latter category.

The pattern of cues which triggered a survivor's anger (see Table, item 3b) was remarkably different than those which triggered her fear and anxiety. The majority of the cues mentioned in response to increased anger reflected ways women are degraded or victimized by society. For example, those cues most often triggering anger were sexual violence (including rape), male arrogance and domination, physical abuse of women by men (e.g. battering) and lack of respect for women by men. In feminist terms, a woman's rape may be viewed as a radicalizing experience for some; an experience which causes an increased sensitivity to and anger with other forms of societal victimization of women.

Only six of these women indicated an increase in depression; of these, 50% felt the depression was general in nature and 50% felt that it was specific. Moreover, the women delineated fewer specific cues or environmental events associated with feelings of depression. It should be noted that these results are based on fewer respondents than the other emotions. However, among these six women, the two circumstances mentioned most frequently as causing depression were general feelings of hopelessness and the general state of life. Only one of the survivors mentioned the rape and rape

related changes in her life as a causal factor for her depression.

One explanation for the less specific findings with regard to depression may be that depression is often a response to general, cognitive stimuli, such as feelings of worthlessness and helplessness, rather then to specifc, external stimuli, such as strange men (Bootzin and Acocella, Note 4). Moreover, Beck (1971) has argued that a critical component in depression is a negative cognitive bias employed by the individual in the interpretation of information about the self and the world. Due to this cognitive component, depression, once triggered, has a tendency to "spread" to other aspects of cognitive functioning. A combination of these two factors would tend to produce a manifestation pattern for depression that was more general then those associated with the other emotions. The patterns of cues stated to be associated with feelings of fear, anxiety, anger, and depression in the current sample support this explanation.

In addition to the above quantitative data several anecdotal reports may also be considered relevant to the state-trait issue. It was observed that several of the women who indicated that their emotional manifestations were general in nature then listed very specific environmental elements that served as triggering agents. Logically, the majority of these elements could be conceptualized as rape related. For example, a survivor might state that she felt fear in response

to the presence of strange men, being alone, or being in the dark. Since cues of this nature occur frequently in the environment of many survivors, an emotion that is specific to certain environmental cues may, phenomenologically, appear quite general in nature. Furthermore, several of the women who indicated that their emotions were either general in nature, or both general and specific at different times, spontaneously mentioned that while a specific, rape related cue might serve to trigger the emotion, once triggered, the emotion began to impact many aspects of their functioning. Again, in these cases, it may be hard to differentiate a state vs. trait change in emotional functioning. However, it may also be argued that rape related cues were most often mentioned because they had been primed by participation in the study and were, therefore, most salient.

While depression seems to represent the most trait-like change in emotional functioning for the rape survivor, it should be noted that increases in depression were reported less frequently than increases in the other emotions tapped (33% for depression, 66% for anger, 100% for fear, and 76% for anxiety). It is also the case that more women in this sample reported decreases in depression than other emotions assessed (44% for depression, 5% for anger, 0% for fear, and 11.7% for anxiety). Therefore, it might be speculated that depression may not represent a long term psychological problem for most rape survivors. This speculation receives some support from

the literature on the shorter-term effects of rape which have reported inconsistent findings on measures of depression in raped women (Ellis et. al., 1981; Atkeson et. al., 1982).

Memories and nightmares. In addition to the emotional changes described above, the majority of the women indicated at least the occasional occurrence of intrusive memories and nightmares (see Table, items 1a & 2a). While two-thirds of the sample were able to indicate a frequency of occurrence for their memories and nightmares (on 7-point scale, from daily to never), approximately one-third of the sample stated that the occurrence of these phenomena were variable. Periods of no memories or nightmares were interspersed with periods during which they occurred frequently. These women indicated that periods of nightmares or memories were closely associated with other factors in their lives, such as their current moods and emotions, and feelings of vulnerability. One interesting finding, not readily obvious from the Table of results, was an apparent negative correlation between the frequency of nightmares and the frequency of intrusive memories. Due to the way in which the question was structured, that is, since the women could mark number 8, the variable option and provide their own explanation of the response, it was impossible to test this correlation statistically. However, an examination of the verbal responses indicated that those women who reported the greatest frequency of nightmares reported the fewest memories of their assaults. One reaction to a trauma

is a need by the survivor to talk about and work through the event (Keiser, 1968; Sutherland and Scherl, 1970). Some rape survivors may be unable to consciously think about or work through the event and, therefore, repress active memories of the assault. The more frequent occurrence of nightmares in these survivors may represent an unconscious attempt to deal with and adjust to the trauma of their rapes. This idea would certainly be related to the psychodynamic theory that repressed feelings and ideas tend to be reflected in the dreams of an individual.

In general, the environmental elements which trigger feelings of anger, anxiety and fear also seem to result in the occurrence of memories and nightmares (see Table, items 1b & 2b). Since feelings of vulnerability and cues of vulnerability for victimization seem to be related to the manifestation of these effects, then one might wonder if a rape serves to sensitize women to these cues in the environment. The data indicated that a rape produces a pronounced increase in the tendency to notice these elements (see Table, item 7c). This tendency results in fairly frequent feelings of vulnerability in many of these women, feelings cued by such common experiences as not beng in control of a situation, strange men and being alone (see Table, item 7a).

Effects on functioning. In general, the women indicated that when any of the effects described above were activated,

mild to moderate disruption of their daily activities was experienced (see Table, items 8a, 9a, 10a, 11a, 12a, & 13a). The emotions of fear and anxiety and the occurrence of nightmares and memories tended to produce very similar phenomenological feelings in the survivor and similar effects on her functioning (see Table items 8b, 9b, 11b, 12b, & 12c). These included various physiological symptoms, irritability, problems with concentration and some decrease in the ability to function adequately. Above we found that these phenomena were cued by many of the same stimuli and tended to occur together. Therefore, it should be expected that the exact nature of the manifestation of any one of the phenomena would be hard to differentiate from the others. Anger (see Table, items 10b & 10c) was also found to produce similar effects although it also tended to upset a survivor's family and cause her some trouble in situations where anger was considered inappropriate (e.g. at her boss, etc.).

It should be noted that many of the survivors made instrumental responses in order to avoid/control disruptions in their lives. For example, 58% of the survivors responsed to fear with hyper-alertness and preperation for attack which reduced the fear level. In response to feelings of vulnerability, 85% of the survivors made responses which involved other people (i.e. call friend) and 72% made responses that involved objects (i.e. obtained a weapon) to reduce these feelings.

Application of two factor learning theory. The results of this pilot investigation indicated that a raped woman does experience a variety of changes in emotional levels which impact and disrupt her daily functioning. In addition, the majority of these women indicated that these effects occurred in response to specific environmental cues. However, it has also been noted that the cues which serve to trigger these emotional states and psychological effects are very common elements in the daily environment of virtually all of the survivors. The issue of whether these effects are dynamic and state-like or static and trait-like may seem to be little more than a issue of semantics, since an emotional state reaction to a continually present set of cues would be indistinguishable, on a phenomenological level, from an emotional trait. The question would indeed be moot except that the pilot data also indicated that the majority of the survivors interviewed were extremely good at constructing and restricting their lives in ways which allowed an avoidance of salient cues and resulted in adaptive psychological functioning.

Before a discussion of the nature of these avoidance strategies it may be helpful to conceptualize a woman's reactions to rape in the context of a two-factor learning theory. This conceptualization has been adopted by some clinicians in the context of therapy with the rape survivors (Becker and Skinner, 1983; Kilpatrick, 1983). According to

this view, a woman's adjustment to rape involves two types of learning; classical conditioning (factor one) and operant conditioning (factor two). In regard to classical conditioning, the rape itself would be considered an unconditioned stimuli (UCS) which provoked a variety of unconditioned responses (UCRs), such as terror and anxiety, in the rape survivor. All elements or stimuli present in the assault situation would then become conditioned stimuli (CSs) with the capacity to evoke conditioned responses (CRs) similar to those reactions experienced during the rape.

Through the process of stimulus generalization, other stimuli, which are similar to the CSs, could also acquire the capacity to evoke the CRs; thus, men who resemble the rapist (or men, in general) or situations that contain elements similar to those present during the rape would elicit conditioned emotional responses in the survivor. Logically, some CSs may be present in virtually all rapes, such as feelings of vulnerability and being alone, while others would be idiosyncratic to a specific rape event, such as the smell of alcohol or the sound of loud cars. This idea is congruent with the patterns of cues that triggered rape related effects in the current sample.

According to the process of operant conditioning (factor two), two expected and common reactions to rape related CSs would be 1) the development of behaviors which would allow the survivor to avoid or escape from these stimuli, and 2) the

development of strategies to discriminate stimuli in the daily environment from assault related CSs. These behaviors would tend to become resistent to extinction as the alleviation of psychological distress associated with the successful avoidance or escape from these CSs would act as a powerful negative reinforcement for these behaviors. This avoidance strategy would serve to maintain the psychological reactions to rape related CSs, as the survivor would never experience a counter-conditioning of more positive reactions to these stimuli due to her avoidance/escape behaviors.

Within the two-factor learning conceptualization, it would be expected that survivors who are less able to avoid or finely discriminate assault related CSs would show a greater dysfunction then those survivors who were more successful in the use of these strategies. Moreover, it would be expected that the more similar the assault environment was to important areas of the survivor's life (e.g. the home or work environment), the more severe would be the effects of the rape on a woman's functioning. The power of avoidance strategies to effect psychological functioning can be clearly seen in the results of Leopold and Dillion (1963) who found that the greatest occurrence of psychological dysfunction in survivors of a marine accident were found in those sailors who had returned to sea and were, thus, unable to avoid salient accident cues.

A raped woman can not avoid the assault environment as

easily as the sailors above; therefore her avoidance/discrimination strategies and their effectiveness are harder to clearly delineate. Yet all of the woman sampled made changes in living and relational style and endured various life restrictions in an attempt to avoid or finely discriminate stimuli that produced deleterious effects on their psychological functioning. Some of the life changes/restrictions reported by these survivors are congruent with those described by Burgess and Holmstrom (1979b) with regard to shorter-term reactions to rape. The exact nature of these behaviors for any given survivor may be understood in the context of the nature of her assault experience. For example, one might expect that women raped at work would show a greater restriction of employment possibilities through the avoidance of any job which was similar to the one held at the time of the assault. The current data offer some support for this notion as one of the survivors who had been raped at a resort were she was employed for the summer, was unable to return to the job, as planned, the following season.

In addition, all but two of the survivors reported changes in living arrangements, such as the need to have roommates, the acquisition of a dog and the taking of various safety precautions (see Table, item 14). The two women who stated that they made no changes were already living under conditions, characterized by these changes, at the time of the assault. Moreover, 90% of the women sampled reported changes

subsumed under living style such as the tendency to carry a weapon, learn self-defense and the cessation of solitary activities (see Table, item 15). The women also showed a tendency to restrict their employability by avoiding various jobs where safety precautions were considered inadequate or which would bring them into contact with elements that would trigger adverse emotional reactions and consequent dysfunction (see Table, item 17). All of these behaviors would result in either an avoidance of assault related CSs (i.e. never being alone avoids CS being alone) or serve to discriminate daily life situations from the assault situation (i.e. a locked environment vs an unlocked environment (CS); being vulnerable (CS) vs not being vulnerable vis-a-vis self defense).

Furthermore, all of these women made changes in the way in which they related to other individuals as an attempt to avoid potential victimization and situations which might cause psychological distress. These relational style changes reflected a tendency to become less friendly with and more distant from men in general while becoming more friendly and closer to women in general (see Table, item 22). For example, 47% of the sample indicated that they trusted women more, 57% that they formed closer bonds with women, and 78% said that they empathized more with women since the assault. Conversely, only 10% of the women indicated that they formed closer bonds with men since the assault, and none of them stated that they trusted or empathized more with men.

Furthermore, 89% of the sample indicated that they had become more suspicious of men since the assault while only 10% indicated this change in regard to women. These data are congruent with Brodsky's (1976) finding that the majority of her sample reported difficuly relating to men. Moreover, approximately two-thirds of the women sampled indicated that they deliberately altered their physical appearance or interpersonal strategies following the rape to discourage men from approaching them (see Table, item 23), and 33% indicated that they were much more selective about the men that they dated (see Table, item 20).

This increased distance between the survivor and men in general can be viewed as an attempt to avoid situations, such as an approach by a strange male, that would be reminiscent of the assault and trigger feelings of vulnerability for further victimization. The increased selectivity with regard to potential male dates may represent a strategy of the survivor to discriminate certain males from the larger group of potential male victimizers. In addition, increased closeness to women may be an attempt by the survivor to surround herself with individuals who, because of increased empathy, may offer support and validation for her experiences. Such an approach is supported by survivors' adjustment strategies. The majority of the women indicated that the presence of understanding, non-judgmental others was essential to their adjustment (see Table, item 24). If, fearing further

victimization, a survivor feels that she must distance herself from men, then women would be seen as the chief potential source of needed support and interpersonal contact.

One problem with the current data is that the survivors answered detailed questions that concerned relational style to men and women in general. While the women answered some questions which regarded relationships with individuals known at the time of the assault, these questions were not as detailed as those which regarded men and women in general. Therefore, we can not conclude that the survivor experienced an increased distancing from males known to her at the time of the assault. According to two factor learning theory it would be predicted that the effect that a rape would have on current male friendships would depend upon the nature of the assault experience. For example, a woman raped by a known and trusted male would be expected to show a greater distancing from male friends then a women raped by a stranger. However the current data was not structured in a way to offer support for this statement. All that can be said about the effects of a rape on current friendships, based on the findings of this project, is that the survivors showed a tendency to become more distant to any individual in the support system, regardless of sex, who responded negatively (i.e. blamed the survivor etc.) at the time of the assault (see Table, item 21).

Positive adjustment strategies/prescriptions. The women in the current sample were asked to delineate reactions

received from significant others which they felt were germane to their positive adjustment (see Table, item 24). Ninety-four percent of these women indicated that non-judgmental, accepting and non-blaming reactions were tantamount. In addition, 82% of the survivors felt that it was important that others allowed them to express their emotions and 76% felt that it was necessary that others simply allowed them to talk about the experience. West and Hughes (1984) also reported that support system reactions can have a profound influence on a survivor's reactions to rape.

The significance of these reactions to rape survivors' positive adjustment is reflected in the prescriptions that these long-term survivors suggested would be helpful to recent survivors of rape (see Table, item 26). Sixty-three percent of the women stated that recent survivors should seek support/help and not try to deal with their rape alone. Twenty-one percent of the women indicated that recent survivors not take blame for the experience and 17% felt that it was important that shorter-term survivors not withdraw from social contact and daily activities.

All of the strategies discussed herein are employed by the survivor because they reduce her perception of vulnerability although they do not necessarily reduce her actual vulnerability. It must be remembered that rape survivors are reacting to an event that has a high probability of reoccurrence. Some of these strategies can be

conceptualized as more valuable then others as they would be more likely to prevent future assaults. For example, a survivor who learned self-defense, bought a large watch dog, or became skilled in the use of a weapon would be less vulnerable to attack then a survivor who lived in second story access housing, had phones in every room, or altered her physical appearance. In light of this distinction, it would be logical to suggest coping strategies to a survivor that would both reduce psychological stress and prevent an attack.

Positive effects accrued through adjustment. All of the women sampled made instrumental responses which allowed them to gain some mastery over the impact of rape on their lives. The power of these women as survivors, rather than victims, can be seen in the fact that 90% of the women stated that some positive effects had accrued from their adjustment process (see Table, item 25). Two of the positive effects mentioned were an increased sense of psychological strength and faith in the ability to survive negative experiences. In addition, some of the survivors indicated that their rape experience had resulted in a greater ability to help other women through similar traumas and an increased awareness of womens' rights or the lack thereof (27% of sample in both cases). An increased caution of and alertness to dangers in the environment (e.g. potential victimization) was also seen as a positive effect for some of the survivors (27%). Based on her work with terminal cancer patients, Shelly Taylor (1983) noted

that these individuals showed "a remarkable tendency to construe personal benefit from potential tragedy" (p. 1163). The current sample of rape survivors also showed this tendency, as was initially suggested by the article by Crescent Dragonwagon (1977).

DSM-III. In general, the reactions to rape experienced by the women in the current sample are strikingly similar to the reactions defined in the DSM III (pg. 236-238) as the Post Traumatic Stress Disorder (PTS; historically referred to as the Traumatic Neurosis). This edition delineates three broad categories of reactions to a traumatic event: (1) a reexperiencing of the trauma; (2) a numbing of responsiveness to or a reduced involvement with the external world; and (3) the presence of at least two of seven described symptoms, such as sleep disturbances and hyper-alertness. Factors that were considered a reexperiencing of the trauma included recurrent and intrusive recollections of the event, dreams of the event, and a sudden acting or feeling as if the trauma were reoccurring because of association with environmental stimuli. The occurrence of memories and nightmares following a rape have been well documented in the current literature (e.g. Burgess and Holmstrom, 1974) and were found in this sample of longer-term survivors. The cued nature of the psychological effects of rape in the current sample is analagous to the sudden acting or feeling as if the traumatic event were reoccurring.

A numbing of responsiveness or a reduced involvment with the external world can be seen in the rape survivors' tendencies to increase the distance between herself and men in general, restrict her employability and stop solitary activities. The third catagory in DSM-III, the symptoms delineated as evidence of the PTS disorder are

1. hyperalertness,
2. exaggerated startle responses,
3. sleep disturbances,
4. guilt about surviving or the behaviors required to survive,
5. memory impairment or difficulty concentrating,
6. avoidance of activities that arouse a recollection of the event,
7. and an intensification of these symptoms by exposure to events that symbolize or resemble the traumatic event.

As indicated by the above discussion, all of these symptoms are found in survivors of rape. Guilt about having survived the trauma, or about behaviors needed to survive, can be illustrated with the use of anecdotal evidence from the present study. It was not at all uncommon for the survivors to preface discussions of their adaptation strategies with phrases such as "you'll think I'm crazy, but" or "I know that I'm stupid, but". These phrases often preceeded descriptions of sensible behaviors such as a failure to stop on a dark lonely road to change a tire, opting instead to ruin the tire rim by driving to a place of safety. Other women stated that their increased dependence on friends for company, a dependence necessary for the alleviation of fear (e.g. survival), made them feel "stupid" or like a "burden".

While the parallels with the PTS are striking there is one factor that serves to differentiate reactions to rape from reactions to other forms of trauma: the nature of the cues which serve to intensify the survivors symptoms. The stimuli with the potential to become conditioned to a rape trauma cover a wide range and are pervasive in the environments of virtually all survivors. As I have stated it is much easier to avoid something like work at sea following a marine accident (Leopold and Dillion, 1963) then it is to avoid the dark, being alone or strange men. Given the nature of the rape event one might expect the rape survivor to develop more elaborate avoidence/escape behaviors and behaviors designed to discriminate aspects within the daily environment that do and do not indicate vulnerability.

Editorial comment. Within this paper I have argued that the behavioral effects of the traumatic experience of rape are adjustment strategies enacted by the survivors to promote healthy psychological functioning. Through my research I have supported the idea that the rape survivors' reactions are consistent with reactions described as Post Traumatic Stress Disorder. However, I have difficulty with the application of the term "disordered" to individuals who display these behaviors.

If an individual who had survived a trauma, such as a rape or a devastating tornado, were to deliberately expose her/himself to a reoccurrence of the trauma, then we would

call that maladaptive; yet, when these individuals develop protective behaviors we call that disordered. At what point do these behaviors cease to be "normal", "healthy" reactions to realistic dangers and become dysfunctional? At what point do a rape survivor's fears become "paranoia" and her concerns for her personal safety "obsessions"? Who is qualified to make this distinction? The distinction is most often made by mental health professionals-few of whom have experienced the event in question. At other times, the distinction is made by the survivors themselves, as when they seek treatment or silently judge themselves as "mentally ill". However, the survivors may make such judgments based on the broader society's lack of support/respect for the functional value of their trauma reactions. I feel that to describe individuals who have adjusted/ are adjusting to a realistic event in the terminology of psychopathology is to further victimize these individuals (i.e. victim blaming; see Ryan,1981).

Implications and Future Research

The above findings have a number of important implications for mental health care professionals and for the judicial system. Mental health care professionals need to be made aware of the nature and endurance of the psychological effects of rape and of the prevalence of rape among women. The importance of such information is dramatically illustrated by a recent study which indicated that 47% of a sample of patients in a mental institution had histories of physical

and/or sexual abuse (Carmen, Reiker, and Mills, 1984). Many women may seek counseling for rape related problems but fail to identify themselves as rape survivors. Some of these women may be unable to discuss the experience; others, as pointed out by Koss (1983), may fail to identify themselves as rape survivors but will evidence the symptoms of the rape trauma syndrome. The latter is particularly true of survivors of date and marital rape. Because some survivors of rape are unable to identify themselves it is vital that mental health care professionals be able to do so and to treat these women accordingly.

In regard to treatment, my findings indicate that the rape survivor develops strategies in an attempt to gain mastery over the experience and its effects on her psychological functioning. Further research needs to be done to more fully investigate the nature of these strategies and their effectiveness in reducing rape related fears and anxieties. With this information therapies, which train survivors in the use of effective strategies and help them to eliminate less adaptive strategies, can be developed. Moreover, information which concerns vital support system reactions and their effect on the survivor's recovery can be used to educate the public to the types of reactions that will ultimately benefit the survivor.

In regard to the judicial system, expert testimony on Rape Trauma Syndrome has been used successfully in court as

evidence that a rape has occurred (see Bristow, in press). As pointed out by Bristow, the defendant and the survivor are generally the only eyewitnesses to the offense and expert testimony is testimony which supports the survivors story and reinforces her credibility. In the absence of other evidence, this testimony can be vital in the establishment of proof that the rape occurred and in the subsequent conviction and sentencing of the perpetrator. Bristow has also pointed out that while expert testimony on the Rape Trauma Syndrome may be helpful in obtaining convictions, evidence on the longer-term effects of rape may be important considerations for civil cases which concern survivor restitution. Research on the severity and nature of the long-term effects of rape can be used to insure that the survivors in civil suits are given settlements that reflect the degree and type of disability associated with their particular reactions.

Finally, further research and documentation of the short and long term effects of rape on the survivors will produce information which can be used to educate the public regarding the true effects of rape on women. Commonly held myths which maintain that women "enjoy" and "ask" to be raped and that rape is, therefore, not really traumatic can be eradicated. The power of such education can be seen in the findings of a study by Malamuth (1981) that indicated that a large percentage of "normal" males who had stated that they would commit rape if it were certain that they would not be caught

changed their minds when the were told of the severity of a typical rape survivor's reaction to such assault. Through the vehicle of public education it may be possible to insure that all victims of rape become survivors.

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Appendix

Appendix A

Rape Assessment Schedule

PARTICIPANTS: BACKGROUND DATA

1. Occupation

	At time of repe	Now
1. Homemaker	_____	_____
2. Pert-time employment	_____	_____
3. Full-time employment	_____	_____
4. Not employed	_____	_____
5. Retired	_____	_____

2. Pleaae chack the category below that corresponds to your average yaerly income (includa apouae's, parents', etc. income, if epplicabla).

	At time of rape	Now
1. 0 - 3,000	_____	_____
2. 3,000 - 7,000	_____	_____
3. 7,000 - 10,000	_____	_____
4. 10,000 - 15,000	_____	_____
5. 15,000 - 25,000	_____	_____
6. 25,000 - 35,000	_____	_____
7. 35,000 - 45,000	_____	_____
8. 45,000 - 65,000	_____	_____
9. 65,000 -	_____	_____

3. How much formal education have you hed:

_____ 1. less than high school
_____ 2. high school
_____ 3. college, technical or trade school
_____ 4. graduate school

4. What ia your ethnic origin?

1. White
2. Black
3. Oriental
4. American Indian
5. Hiapanic
6. Other (pleaaa specify)

5. What ia the population in tha town/metropolitan eraa where you spent the majority of your childhood and adolescent years (pleaae specify town name: if livad in country, apecify and give population of neareat town)?

6. What ia the populetion of tha town/metropolitan aree where you now live (plaaaa apecify town name: if you live in the country, apecify and giva population of nearest town)?

7. Would you aay that you had an urban (city) or rural (country) background?

1. rural
2. urban

8. How much network (CBS, NBC, ABC) taleviaion do you watch per week (pleaae exclude news broadcests)? [code houra par week]

9. How much aducational (PBS) televiaion do you watch per waak? [code hours per week]

10. How many hours of televised news broadcasts do you watch per week? [code hours per week] __ __

11. On the average, how many theater movies (include HBO, Showtime, etc.) do you see per month? [code number of movies per month] __ __

12. How often do you read the newspaper? [code number read per month] __ __

13. What magazines do you read regularly?

Please give a general description of your rape experience.

14. Your age at the time of your assault. Your age now.

now _____
sssault _____
intsrval _____

15. What time of day did ths assault occur?

1. day
2. evening
3. slasptime

16. Was it dark outside?

1. light outside
2. dark outsida

17. Whera did the assault occur?

1. victim's home
2. school
3. work
4. car
5. rapist's home
6. sacluded aetting
7. other (specify) _____

18. Do you consider the araa in which the assault occurrad to be an urban or a rural area?

1. rural
2. urban

19. How well did you know the assailant? Plassa indicats your rssponss on the following scale.

1	2	3	4	5	6	7
total stranger						knsw extremely well

20. Would you consider him (thcm) a atrangar or an acqusintsncs?

_____ 1. stranger
_____ 2. acquaintancs

21. How long did the apisode last? [code hours in decimals]
s.g. 00.5 is 1/2 hour

22. How many persons had sexual contact with you?

0. missing data
1. aingle rapist
2. multipls rapists

23. How many persons participated in the assault?

0. missing data
1. aingle assailant
2. multiple assailants

24. Hava you (or any of your family, close acquaintances) had any further contact with your assailsnt(s)?

1. No
2. Yes

If yee, whet hee been the nature of thie contect?

b. Do you feel thet thie contect affected your edjuetment to the eeeeult? If yee, in whet wey.

25. If you were phyeicelly harmed during the eseeult, pleeee deecribe the neture of theee injuriee. [Ask open ended; record reepooee, then code into cetegoriee]

1. was not physicelly hermed
2. wee roughed up elightly
3. wee moderately beeten
4. wes severely beeten
5. euffered eevere injury-mutiletion but not death ___

26. During the eesault, whet degree of feer did you experience in regerd to your phyeicel eefety?

1. did not fear thet I would be phyeically hermed
2. feered I might be roughed up slightly
3. feared I might be eeverely beeten
4. feared eevere injury-mutiletion but not deeth
5. feered deeth ___

27. Whet wee your greateet feer during the aeeeult?
[Aek open ended; retein reeponee but code as below]

0. miesing data
1. deeth
2. not deeth ___

28. e. Did your repe reeult in e pregnancy?

1. No
2. Yee ___

b. If yee, deecribe that experience

c. Do you feel thet eny problems you've had eince the aeeeult ere the result of your pregnency or related events? If yee, describe.

29. Do you feel that any of your moral convictions (i.e. attitudes about virginity and marriage, pregnancy, abortion, etc.) at the time of your assault affected your reactions to your assault? If yes, what were the convictions and what effect did they have on your reactions? [Ask open ended, then categorize; retain one response]. (0 = no, 1 = yes for each category)

1. ____ traditional ideas about virginity & marriage
2. ____ belief in the "Good Woman" myth
3. ____ other

30. a. Do you feel that because of your assault, any of your moral convictions have changed?

b. If so, how have they changed? [Ask open ended and then categorize; retain one response]. (0 = no, 1 = yes)

1. _____ became temporarily more promiscuous
2. _____ in general, became more promiscuous
3. _____ changed from pro-life to pro-choice (in regard to abortion)
4. _____ became very anti-sexual assault
5. _____ changed mythical attitudes about rape (shattered myths)
6. _____ obtained stricter values against flirtatious behavior in women
7. _____ other

31. Please indicate on the following 7-point scale your tendency to read material and/or watch programs about rape.

1	2	3	4	5	6	7
never, I avoid depictions of rape			I neither seek out or avoid depictions of rape			I try to read/ watch all material about rape that come to my attention

32. Do you feel that your tendency to want to read material and/or watch programs about rape has changed since your assault? If so, how has it changed?

1	2	3	4	5	6	7
great decrease in tendency			no change in tendency			great increase in tendency

33. Were you a virgin at the time of the assault?

1. not virgin
2. virgin

34. Were there any other major life events or changes (living on your own for the first time, starting college or a new career) occurring in your life at the time of the assault.

1. No
2. Yes

If yes, please describe

35. Did (or have) you experience(d) any sexual problems as a result of the assault? If yes, what kinds of problems did you experience and how long did the problems last. [Ask open-ended, then catagorize by type and length; retain o-e response; 000 = No, 999 = N/A, for yes, code number of years in decimal__._, e.g. 12.5]

	Problem	Length of endurence
1. _____	Fear of sex	___ ___ ___
2. _____	Desire dysfunction	___ ___ ___
3. _____	Arousal dysfunction	___ ___ ___
4. _____	Orgasmic dysfunction	___ ___ ___
5. _____	Veginismus	___ ___ ___
6. _____	limitations on activities (e.g. no anal, no "wild abandon", only gentle sex")	___ ___ ___
7. _____	other	___ ___ ___

36. Have you noticed changes in the general patterns of your dating and/or sexuel reletionships that you attribute to your assault? If yes, what kinds of changes have you noticed? [Ask open-ended first, retain o-e response; then have woman review categorize]

(For each of the following, score "0" for no and "1" for yes response.)

a. _____ Having to be in control of the sexual encounter (e.g., has to be the one to initiate, has to be in exactly the right mood, etc.) ___
b. _____ Is much more selective about men (dates less, has to know well, won't go out to bars alone and get picked up, etc.) ___
c. _____ Changed sexual preference from men to women/ or made change easier. ___
d. _____ Much more distant/non-affectionate with men. ___
e. _____ No longer (or seldom) engages in flirtatious behavior. ___
f. _____ Other ___

37. Where do you live now? [Code 1 = single unit dwelling; 2 = multiple unit dwelling; retain original response.]

1. home
2. apsrtment
3. trailer
4. rooming house
5. dormitory or sorority house
6. other (specify)
7. no data

38. Who do you live with now? [Code = # aaaociated with responae checked]

1. live alone
2. live with mate/lover only
2. live with roommate(s) only
2. live with mate & children
2. live with parents/relatives & children
2. live with children
2. other (specify)
0. no data

39. Have you experienced any of the following changes in your living arrangements and/or conditions as a result of your rape. [code 0 = no changes; if changes, each change = 1]

a. _____ roommate(a)
b. _____ dog
c. _____ 2nd floor access
d. _____ aafety precautions (locks, bars, guns, booby traps, etc.)
e. _____ need to know the neighbors
f. _____ other (1 point for each meotioned)

40. Have you experienced any of the following changes in your atyle of living as a result of your assault. [Code 0 = no changes; each change = 1].

a. _____ learned self defense
b. _____ began carrying a weapon of some type (e.g. nail file, knife, gun, mace, etc.)
c. _____ hesitant to go out of house alone at night
d. _____ hesitant to go out of house alone during day
e. _____ drive with car doors locked
f. _____ other (1 point for all othera indicated)

41. Liated below are a number of activitiea. Please review each activity and indicate on the 7-point scale the degree of comfort/discomfort you would feel if you were doing the activity.

1 2 3 4 5 6 7

extremely comfortable — extremely uocomfortable

a. _____ walking alone during the day.
b. _____ walking alone at night.
c. _____ driving alone during the day.
d. _____ driving alone at night.
e. _____ engaging in activities alone (going out to eat, to the movies, traveling, etc.)

42. Listed below ere severel statements thet concern your feelings of security in different snvironments. Please use the following scale to rsspond to each statement.

1	2	3	4	5	6	7
very secure						not at all eecure

a. _____ ln generel, how secure did you feel when you were home elone et night before the assault? ____

b. _____ ln general, how secure do you fael when you ere home elons at night? ____

c. _____ ln general, how secure did you feel when you were et home alone during the dsy before your essault? ____

d. _____ ln general, how secure do you now feel when you ere home alone during ths dsy? ____

43. We sre interssted in what you, es e rape survivor, feel is the moet importent thing thst you have done or fael thet you could do to make yourself fsel more secure. ls there one thing that does or could make you feel more secure when you are home alone?

1. No
2. Yes ____

44. lf yes to #43, what is that thing?

45. How secure does or do you think the above item(s) would make you feel? ____

1	2	3	4	5	6	7
very secure						not at all sscure

46. Listed below are several general descriptions of certain typee of jobs. Please evaluste each job description end indicate, with the uee of the seven point scele, the dsgree of comfort/discomfort thst you would expsrience in regard to the job.

1	2	3	4	5	6	7
very comfortable, would have no trouble taking the job						extremely uncomfortable, could not take the job

a. _____ A job which requirad a high degree of contect with men. For exsmple, working at a truck stop or as e barber. ____

b. _____ A job which in some wsy reminded you of the esseult. For axsmple, doing social work if you were e social worker who was asssulted while on a case. ____

c. _____ A job in which ssfety precautions were e potential concern. Such as working alone or in a rough area of town. ____

d. _____ A job in which men or s man hsd power over you. For example, as a secretary for a male employer. ____

e. _____ Any night-time job. ____

47. If you were working at the time of the assault, did you retain your job?

0. Was not working at time
1. Was working and retained job
2. Was working but chose to quit
3. Was working and was fired

48. If you were working at the time of the aasault, was your ability to work disrupted? If yes, please indicate the degree of the disruption on the following scale.

1	2	3	4	5	6	7
work ability was not disrupted			work sbility was moderately disrupted			work ability was severely disrupted

49. If your ability to work was disrupted by the aasault, what was the exact nature of these disruptions?

50. Were you in school at the time of the aasault?

0. Not in school
1. Was in school and remained in school
2. Was in school but chose to quit
3. Was in school but flunked out

51. Was your schoolwork disrupted? Please indicate the degree of diaruption on the following acale.

1	2	3	4	5	6	7
school work not diarupted			school work was moderately disrupted			achool work was severely disrupted

52. If your school work was disrupted, what was the exact nature of these disruptions?

53. What people (or person) were the most helpful when you told them about the assault? [code for type and for number of type]

1. Told no one (code 00)
2. family member(s) (If 5, code 05)
3. close friend(s)
4. profeasional(s)
5. other(s)

54. What did they do that helped? [Ask open-ended, then categorize; retain o-e response; 0 = no, 1 = yes)

a. _____ accepted me (non-judgmental; did not blame survivor etc.)
b. _____ defended me to others who were blaming me in some way for the assault
c. _____ gave me someone to talk to
d. _____ told me of places to get help
e. _____ told me of others who had been raped
f. _____ shared their rape experience with me
g. _____ allowed me to express my emotions
h. _____ stayed with me (physically) or allowed me to stay with them (assured safety)
i. _____ helped me press charges
j. _____ told me what to expect in terms of the effect of rape on a woman
k. _____ other

55. This question concerns the types of responses that you, as a rape survivor, have received when you have told others about your rape experienca, or when others found out about it. The categories below correspond to general types of responses that you may have received. Please check each category that you feel represents a response that you received.

For each category checked, please use the associated scales to indicate hov significant the effect of that response was on your overall adjustment and/or whether the effect was positive or negative. Please concentrate on resctions that you received from those people who were important to you and whom you considered to be a part of your support system.

[Coders: Total score = (Pos-nag rating X significance rating) ;"Code 0 if the response did not occur, was not applicable.]

-3	-2	-1	+1	+2	+3
extremely negative	somewhat negative	slightly negative	slightly positive	somewhat positive	extremely positive

1	2	3	4	5	6	7
not at all significant			moderately significant			extremely significant

a. The person was very accepting of you and did not blame you in anyway for the assault.

1. _____ pos/neg rating
2. _____ significance rating
3. _____ 1 x 2

Why did you rate this response as you did on the above scales. In other words what did this response mean to you?

b. The person refused to believe that you had been raped and acted as if you had made the whole thing up.

1. _____ pos/neg rating
2. _____ significance rating
3. _____ 1 x 2

-11-

-3	-2	-1	+1	+2	+3
extremely negative	somewhat negative	slightly negative	slightly positive	somewhat positive	extremely positive
1	2	3	4	5	6	7
not at all significant			moderately significant			extremely significant

Why did you rate this response as you did on the above scales. In other words what did this response mean to you?

c. The person indicated that they did not believe that the experience was actually a "rape".

1. _____ pos/neg rating
2. _____ significance rating
3. _____ 1 x 2

Why did you rate this response as you did on the above scales. In other words what did this response mean to you?

d. The person defended you to others who were in some way blaming you for the assault.

1. _____ pos/neg rating
2. _____ significance rating
3. _____ 1 x 2

Why did you rate this response as you did on the above scales. In other words what did this response mean to you?

e. Angry that the experience had happened, but not angry with you.

1. _____ pos/neg rating
2. _____ significance rating
3. _____ 1 x 2

Why did you rate this response as you did on the above scales. In other words what did this response mean to you?

-3	-2	-1	+1	+2	+3
extremely negative	somewhat negative	slightly negetive	slightly positive	somewhat positive	extremely positive

1	2	3	4	5	6	7
not at all significant			moderately significant			extremely significant

f. Blamed you in some way for the experience.

1. _____ pos/neg rating
2. _____ significance rating
3. _____ 1 x 2

Why did you rate this response as you did on the above scales. In other words what did this response mean to you?

g. Told you of their own rape experience or of the experience of others who had been raped.

1. _____ pos/neg rating
2. _____ significance rating
3. _____ 1 x 2

Why did you rate this response as you did on the above scales. In other words what did this response mean to you?

h. Indicated that the rape wasn't very important and/or that you should not be upset about it.

1. _____ pos/neg rating
2. _____ significance rating
3. _____ 1 x 2

Why did you rate this response as you did on the above scales. In other words what did this response mean to you?

-3	-2	-1	+1	+2	+3
extremely negative	somewhst negative	slightly negative	slightly positive	somewhst positive	extremely positive

1	2	3	4	5	6	7
not at all significent			moderately significant			extremely significent

i. Reacted as if the rape was a major life trauma from which you would never recover.

1. _____ pos/neg rating
2. _____ significance rating
3. _____ 1 x 2

Why did you rate this response as you did on the above scales. In other words what did this response mean to you?

j. Allowed you to express your emotions and indicated that it was alright for you to feel the way that you did.

1. _____ pos/neg rating
2. _____ significance rating
3. _____ 1 x 2

Why did you rate this response as you did on the above scales. In other words what did this response mean to you?

k. Reacted with pity.

1. _____ pos/neg rating
2. _____ significance rating
3. _____ 1 x 2

Why did you rate this response as you did on the above scales. In other words what did this response mean to you?

l. Reacted as if you were permanently "changed" or "damaged".

1. _____ pos/neg rating
2. _____ significance rating
3. _____ 1 x 2

-3	-2	-1	+1	+2	+3
extremely negative	somewhat negative	slightly negative	slightly positive	somewhat positive	extremely positive

1 not at all significant 2 3 4 moderately significant 5 6 7 extremely significant

Why did you rate this response as you did on the above scales. In other words what did this response mean to you?

m. Allowed you to stay with them (or stayed with you) and/or encouraged you to call them anytime that you needed them.

1. _____ pos/neg rating
2. _____ significance rating
3. _____ 1 x 2

Why did you rate this response as you did on the above scales. In other words what did this response mean to you?

n. The person was extremely supportive at first but then lost patience with you when they felt that you should have recovered.

1. _____ pos/neg rating
2. _____ significance rating
3. _____ 1 x 2

Why did you rate this response as you did on the above scales. In other words what did this response mean to you?

o. Indicated that they felt that you were a very strong person (emotionally) and would be able to adjust to the experience in spite of its severity.

1. _____ pos/neg rating
2. _____ significance rating
3. _____ 1 x 2

Why did you rate this response as you did on the above scales. In other words what did this response mean to you?

-3	-2	-1	+1	+2	+3
extremely negative	somewhat negative	slightly negative	slightly positive	somewhat positive	extremely positive

1	2	3	4	5	6	7
not at all significant			moderately significant			extremely significant

p. The person became very protective of you; almost overprotective.

1. _____ pos/neg rating
2. _____ significance rating
3. _____ 1 x 2

Why did you rate this response as you did on the above scales. In other words what did this response mean to you?

q. The person pressured you to do things that you felt you were not ready to do (i.e. to press charges, to begin dating, etc.)

1. _____ pos/neg rating
2. _____ significance rating
3. _____ 1 x 2

Why did you rate this response as you did on the above scales. In other words what did this response mean to you?

56. What kinds of reactions did you receive that you would classify as supportive? [Ask open-ended; retain open response; then have woman review categories; 0 = NR, 1 = open ended, 2 = cued]

1. _____ Anger at the rapist.
2. _____ Laying absolutely no blame on the survivor.
3. _____ Proud of the survivors courage to press charges.
4. _____ Let the survivor talk or encouraged her to talk.
5. _____ Indicated that the survivor was not "damaged" or different than before the assault.
6. _____ Other

57. Did the types of reactions that you received when you told people about the assault change how you felt about your relationships with those people, either in a negative or a positive way? If yes, please describe the nature of these changes. [Ask open-ended and then code into categories, retain open response]

0. No change
1. If person reacted in a positive fashion, felt closer
2. If person reacted in a negative fashion, felt more distant, lost respect, etc.
3. Both 1 and 2
4. Other

58. Did your assault and related experiences affect your relationship with your family? If yes, how? [Ask open-ended, then categorize, retain o-e responses; 0 = NR; 1 = yes]

1. _____ resented male family members (because of negative attitudes towards women, etc.). ____
2. _____ became more-protective of children-family. ____
3. _____ loss of respect for/or problems dealing with family members who responded in a negative fashion. ____
4. _____ resented parent(s) for not telling her more about sex/facts-of-life so might have avoided incident. ____
5. _____ became closer to family members who responded in supporting ways ____
6. _____ other ____

59. In terms of changes that occurred after the assault, which of the following describes how you feel about each group. Please feel free to qualify any of the responses so that they best reflect your own experience. For each response you can check (✓) if the statement applies to either women or to men or to both. [Coders: 0 = NR; 1 = women; 2 = men]

	Women	Men	Response		
a.	_____	_____	(d) I don't date anymore.	___	___
b.	_____	_____	(d) I date only after knowing women(men) well.	___	___
c.	_____	_____	(d) I'm not as open with women (men).	___	___
d.	_____	_____	(d) I lost some of my women (men) friends as a result of the assault.	___	___
e.	_____	_____	(c) We're closer than we used to be.	___	___
f.	_____	_____	(c) I form closer bonds with women (men) than before.	___	___
g.	_____	_____	(c) I trust women (men) more.	___	___
h.	_____	_____	(c) I empathize with women (men) more.	___	___
i.	_____	_____	(e) I have more women (men) friends than before the assault.	___	___
j.	_____	_____	(d) I don't make new female (male) friends as easily as I used to.	___	___
k.	_____	_____	(d) I don't feel comfortable with women (men) I don't know well.	___	___
l.	_____	_____	(d) I don't feel comfortable with women (men) in general.	___	___

m. _____ _____ (c) I feel more comfortable with e woman (man) around in eome situstione (if checked this, plesee indicete whst types of aituetiona) ____ ____

n. _____ _____ (d) 1 am more euspicioue of women (man) that 1 don't know well ____ ____

o. _____ _____ (d) 1 try to avoid women (men) who 1 don't know well. ____ ____

p. _____ _____ (d) 1 avoid being alune with women (men) 1 don't know well. ____ ____

q. _____ _____ (d) 1 won't talk to women (men) 1 don't know well. ____ ____

r. _____ _____ (d) 1 don't like being eround women (men) with power over me (boss, atc.) ____ ____

s. _____ _____ (d) 1 feel threstened by women (men) with power over me. ____ ____

t. _____ _____ other ____ ____

60. Have you evar received counseling becauee of your rapa axparianca? [1f no, go to #66]

1. No
2. Yes ____

61. If you have received counseling, where? [1 = yee for eech plece]

1. _____ repe crisie center
2. _____ locel wental health centar
3. _____ privste therepiet
4. _____ informal support group
5. _____ other (specify

62. How long efter the eeesult did you firet aeek counseling? [Code yeara in decimals] (1 week = 00.02)

63. How long did the therspy lest? [code yeera in decimala es in #61]

64. How helpful was the therapy which regsrded your rape end repe related probleme? ____

1	2	3	4	5	6	7
very helpful						not et all helpful

65. Why did you consider the therspy helpful or not helpful? [Ask open-ended end then categorize, retain o-e reeponee; code "0" if no reeponae end code "1" for each statement thst appliee]

e. _____ told whet to expect in tarms of her own reectione to repa ____
b. _____ did not bleme aurvivor, non-judgmentel, eccepting, etc. ____
c. _____ other ____

66. Have you ever been involved in therapy for other problems end hed the repa come up?

1. No
2. Yes ____

If yes, plesee briefly describe:

67. Did you report your assault to the police?

1. No (if no, go to #69)
2. Yes

68. If you did report your assault to the police, do you feel that your experience with the police affected how you reacted to the assault, either in a negative or in a positive way? Please indicate your response on the following scale.

-3	-2	-1	0	+1	+2	+3
had an extremely negative effect on reaction			do not feel that it affected reaction			had an extremely positive effect on reaction

69. Did you take your assailant to court?

1. No (if no, go to #71)
2. Yes

70. If you did take your assailant to court, do you feel that your court experience affected how you reacted to the assault, either in a positive or negative way? Please indicate your response on the following scale.

-3	-2	-1	0	+1	+2	+3
had an extremely negative effect on reaction			do not feel that it affected reaction			had an extremely positive effect on reaction

71. Have you ever had any other traumatic experiences that have affected you in a similar way as the assault?

1. No (if no, go to#75)
2. Yes

72. If you have had another traumatic experience(s), what was the experience(s) and when did it occur?

73. In what ways were the effects of that experience similar to the effects of your rape experience?

74. In what ways were the effects of that experience different from your rape experience?

75. Have you had any other experiances which you would classify as sexual assault? [As open-ended; retain o-e responsa] ____

0. No
1. Yes

76. Have you experianced any of tha following? [0 = no; 1 = yas] (Coder, make note if c. or d. was completed).

a. _____ been forcad, by your husband, to heve sexual intarcoursa againat your will. ____
b. _____ been forcad, by someone that you were dating, to have sexual intercourse against your will. ____
c. _____ been pressurad to hava sexual intarcouraa by someone who had power over you, such as by an employar or a teachar. ____
d. _____ as a child were you ever subjacted to sexual advancea made by an adult. ____

77. Do you feel you have had increased physical illnass and/or visits to the physician since the assault? ____

1. No (if no, go to #79)
2. Yes

78. If yes to #77, please review health problems listad below, indicate which you hsve experienced and whether you feel that they are or are not due to the assault. [Coder: 0 = does not experience the problem, 1 = has problam but does not attribute it to her assault, 2 = has problem and attributes it to her assault, 3 = has problam and isn't sure if it is related to her assault]

a. _____ rapid or pounding heartbeats ____
b. _____ tension haadaches ____
c. _____ stomach ache or nausea ____
d. _____ asthma attacks ____
e. _____ back pain ____
f. _____ blackout spells, fainting ____
g. _____ seizures ____
h. _____ neckaches ____
i. _____ muscle cramps (non-menstrual) ____
j. _____ high blood pressure ____
k. _____ migraine haadaches ____
l. _____ colitis, spastic colon ____
m. _____ ulcers, stomach or duodenal ____
n. _____ sudden weight loss or gain without dieting ____
o. _____ irregular menstrual periods ____
p. _____ severe menstrual cramps ____
q. _____ allergies ____
r. _____ skin disorders (eczema, acne, etc.) ____
s. _____ anal or vaginal problems ____
t. _____ other ____

79. Do you fael like your use of drugs and alcohol, or your attitudes toward their use, has changed as a result of the assault? If yes, what is the nature of these changes? [Ask open-ended and then categorize; retain o-e response; 0 = NR; 1 = yes for each category]

a. _____ increased use of sedatives (alcohol, marijuana, valium, etc.) ____
b. _____ decreased use of all drugs (including alcohol) due to a need to be in control ____
c. _____ decreased tolerance of the use of drugs (including alcohol) by others ____
d. _____ increased desire to use drugs (including alcohol) but doesn't actually do so ____
e. _____ other ____

80. Were you under the influence of drugs or alcohol at the time of your assault?

1. No
2. Yes ____

81. If you were under the influence of drugs/alcohol at the time of the assault, do you feel that this affected the way in which you reacted to the asault? If so, in what way?

82. Do you hsve nightmares that concern your assault or in which you ara assaulted or threatenad with assault?

1. No (if no, go to #87)
2. Yes ____

83. Now often do you have these nightmares?

1. never
2. very rarely (less frequently than once a year)
3. seldom, no more than once a yaar
4. several times a year
5. once a month
6. several times a month
7. often, at least once a week
8. other (for example, it varies) ____

84. Does anything in particular seem to be ralated to when you have nightmaras? [Ask open-ended first, then categorize, retain o-e response; then have participant review categories below; for each rasponse code 0 = no; 1 = opan-ended; 2 = cued]

a. _____ not sure if anything specific triggers ____
b. _____ cues relatad to rape in general (Crisis Center ads, TV programs, etc.) ____
c. _____ cues related to survivor's rape (men who look lika rapist, etc.) ____
d. _____ anything which concerns sexual violenca or battering ____

e. _____ discussing rape
f. _____ sexual problems
g. _____ restimulation of any memory of an event which occurred around the time of the assault (asking what survivor did that year, etc.)
h. _____ after situations which made you feel vulnerable or when feeling vulnerable
i. _____ other

85. If you do heve nightmares, do they disrupt your daily functioning? Please indicate degree of disruption on the following acale. [Coder: if indicate that degree of disruption varies, code 9]

1	2	3	4	5	6	7
not at all disruptive			moderately disruptive			severely disruptive

86. If your nightmares are disruptive, please deecribe the nature of these disruptions. [Ask open-ended, retain o-e response; then have woman review categories below; 0 = no, 1 = open-ended, 2 = cued]

a. _____ numbness, feels no emotion at all
b. _____ withdrawn (quiet, won't talk, etc.)
c. _____ inability to concentrate (spaciness)
d. _____ inebility to function adequately (can't work well or do normal activities well, etc.)
e. _____ totally non-functional (can do nothing, sits and stares, etc.)
f. _____ jumpy, nervous or irritable
g. _____ tiredness, weariness, lethargy, etc.
h. _____ unable to be alone
i. _____ other

87. How often do you have memories that concern your assault? (if never, go to #91)

1. never
2. very rarely, but occasionally
3. seldom, no more than once a year
4. several times a year
5. once a month
6. several times a month
7. often, at least once a week
8. other (for example, it varies)

88. Does anything in particular seem to be related to when you have memoriea? [First ask open-ended; retain o-e response; then have participant review categories below: 0 = no; 1 = open-ended; 2 = cued for each responae]

a. _____ not sure if anything specific triggers
b. _____ restimulation of memory of any event which occurred around the time of the assault (asking what survivor did that year, etc.)
c. _____ thinking about men
d. _____ anything to do with rape or sexual violence (Crisis Center ads, TV program, etc.)
e. _____ if anyone startles survivor
f. _____ cues specific to survivor's rape (men who look like rapist, etc.)
g. _____ being in vulnerable situtions or when feeling vulnerable (alone, fearful, etc.)
h. _____ other

89. When you have memories of your asseult, do they disrupt your deily functioning? Please indicete degree of disruption on the following 7-point scale. [Codera: if indicate thet varies, code 9]

1	2	3	4	5	6	7
not at all disruptive			moderately disruptive			severely disruptive

90. If your memories are disruptive, please describe the nature of the disruption. [Ask open-ended, retain o-e response; then have woman review categories below; 0 = no; 1 = open-ended, 2 = cued for each respoose]

a. _____ must use energy to get back to pre-memory state-disrupts what doing
b. _____ extreme feer
c. _____ phyaiological symptoms (neusee, heart recing, sweet, etc.)
d. _____ withdrawn (quiet, won't talk, etc.)
e. _____ insbility to concentrate, difficulty etteoding, speciness, etc.
f. _____ lack of emotioo/feeling
g. _____ inability to function adequately (cen't work well, do normal activities well, etc.)
h. _____ totally non-functional (can do nothiog, sits end sterea, etc.)
i. _____ other

91. Is your level of anger different now than it wss before your aaaault? Please indicate your reaponse on the following 7-point scale, 4 indicates no change. [if no change, go to #98]

1	2	3	4	5	6	7
much less anger			no chenge			much more enger

92. If you have experienced an increase in anger since your assault, is the enger triggered by certain types of things or situetions or do you feel that the anger is more general in nature, causing you to be more easily engered in all aitustions? [Ask open-ended, then categorize; retein o-e response]

1. apecific
2. general
3. both, at different times

93. What sorts of things make you angry? Please try to be as apecific as possible. [Firat ask open-ended, retain o-e response, then have woman review categories below: 0 = no, 1 = open-ended, 2 = cued for each response]

a. _____ anything to do with rape and sexual violence. ____
b. _____ male arrogance-dominance ____
c. _____ male ignorance ____
d. _____ verbal abuse of women by men (threats, etc.) ____
e. _____ physical abuse of women by men ____
f. _____ women putting themselves in dangerous positions (in terms of vulnerability to rape) ____
g. _____ women who refuse to take rape seriously ____
h. _____ statements which reflect rape myths (women deserve-enjoy rape, etc.) ____
i. _____ lack of respect for women ____
j. _____ bystander apathy ____
k. _____ lack of understanding/compassion for survivor (blaming victim, should get over fast, etc.) ____
l. _____ other ____

94. When you are feeling angry, what do you do with the anger (how is it expressed)? [Ask open-ended first, then categorize; retain o-e response: 0 = no, 1 = yes for each category]

a. _____ try to be rational ____
b. _____ shake, cry, etc. ____
c. _____ rage, tantrums, break things, rant and rave, etc. ____
d. _____ verbally addresses source of anger (argue, etc.) ____
e. _____ doesn't overtly express-becomes tight, tense, quiet, etc. ____
f. _____ self-abusive ____
g. _____ "why me?" ____
h. _____ other ____

95. If your level of anger has changed, do you find this change disrupts your life? Please indicate your response on the following 7-point scale. ____

1	2	3	4	5	6	7
not at all disruptive						very disruptive

96. If you find that your change in anger is disruptive, how is it so? [Ask open-ended, then categorize, retain o-e response: 0 = no, 1 = yes for each category]

a. _____ anger is inappropriate in some situations ____
b. _____ disrupts-upsets family ____
c. _____ make physiologically ill ____
d. _____ other ____

97. If you have experienced a decrease in anger, to what do you attribute this?

98. Is your level of anxiety different now than it was before your aaaault? Please indicate your response on the following 7-point acale, 4 equala no change. (if no, go to #104)

1	2	3	4	5	6	7	
much lesa anxiety			no change			much more anxiety	____

99. If you have experienced an increase in anxiety aince your aaaault, ia the anxiety triggered by certain types of things or aitutions or do you feel that the anxiety is more general in nature, cauaing you to become anxioua more easily in all situations?

1. apecific
2. general
3. both at different times ____

100. What sort of things make you feel anxious? [Ask open-ended and retain o-e reaponae; then have woman review the categories below: 0 = no, 1 = open-ended, 2 = cued for each responae]

a. ____ rape atimuli apecific to woman'a aaaault (men who look like rapiat, dark, etc.) ____
b. ____ general rape related stimuli (ahowa about rape, Crisia Center ada, etc.) ____
c. ____ men refusing to take the iaaue of rape aeriously (if men won't liaten, rape will never stop) ____
d. ____ being alone ____
e. ____ when feelings vulnerable (not in control if aituation, what happening to her, exposed) ____
f. ____ men, in general ____
g. ____ new situations ____
h. ____ it varies ____

101. If your level of anxiety has changed, do you find thia change diarupts your life? Please indicate your responae on the following 7-point acale.

1	2	3	4	5	6	7	
not at all diaruptive						very diaruptive	____

102. If you find your change in anxiety diaruptive, how is it ao? [Ask open-ended and then categorize, retain o-e reaponse; 0 = no, 1 = yes for each category]

a. ____ avoids or ia uncomfortable in new aitutions ____
b. ____ avoids being or ia uncomfortable being alone ____
c. ____ lack of concentration, trouble attending, etc. ____
d. ____ jumpy, nervous or irritable ____
e. ____ inability to function adequately (can not do normal daily taaks well, etc.) ____
f. ____ totally non-functional (sits and atares, etc.) ____
g. ____ other

103. If you hsve experienced a decrease in snxiety, to whst do you attributa this?

104. Is your level of fesr diffarant now thsn it was before your asssult? Plessa indicate your response on the following 7-point scala, 4 aquals no change (if no, go to #111)

1	2	3	4	5	6	7	
much less fesr			no chsnga			much mora fear	____

105. If you hsve experiencad an increase in fear sinca your asssult, is the fesr triggered by certsin typas of things or situstions or do you fael that your fasr is more genersl in nature, csusing you to become fesrful more aasily in all situstions?

1. specific
2. genersl
3. both at different times

____

106. What sort of things seem to make you fearful? [Ask open-endad first, ratsin o-e response; then hsve woman review the cstegories below: 0 = no, 1 = open-ended, 2 = cued for asch response]

a. _____ stimuli specific to the woman's rape (men who rasembla tha rapist) ____
b. _____ cues sbout rape in genersl (hesring of other rapes, Crisis Cantar sds, etc.). ____
c. _____ dark, slone, walking st night, strsngers ____
d. _____ people stsrtling her (walking up from behind, snything unexpected, etc.) ____
e. _____ rasding sbout rspa myths and raalizing people balieve this ____
f. _____ whan feeling vulnersble (out of control, opan to sttack) ____
g. _____ other ____

107. How is this fear expressed? What do you do whan you'ra feeling fesrful? [Ask open-anded, then cstagorize; retsin o-e response: 0 = no, 1 = yes for each cstegory]

s. _____ physiologicsl-sutonomic response (stomach motility, sweat, trembling, hesrt rsces, dryness of mouth, tightness, etc.) ____
b. _____ crying-hysteria ____
c. _____ instrumentsl responses-things to attempt to insure ssfety (turning on lights, wespons, leaving frightening situations, life-restrictions, etc.) ____
d. _____ hyper-slert, very csutious ____
e. _____ trys to act emotionslly strong, won't openly express, acts tough ____
f. _____ freezes-psnics (withdrswn) ____
g. _____ hss difficulty functioning adequstely (csn not do dsily tssk well, atc.) ____
h. _____ other ____

108. If your level of fear has changed since your assault, do you find this change disrupts your life? Please indicate response on following 7-point scale.

1	2	3	4	5	6	7	
not at all disruptive			moderately disruptive			very disruptive	____

109. If you find your change in fear disruptive, how is it so? [Ask open-ended, then categorize, retain o-e response: 0 = no, 1 = yes for each category]

a. _____restricts activities ____
b. _____ withdrawn (quiet, won't talk, etc.) ____
c. _____ disrupts family ____
d. _____ difficulty functioning adequately (can't do daily activities well, etc.) ____
e. _____ jumps, nervous, irritable, etc. ____
f. _____ yell, argue, etc. ____
g. _____ numb, freezes ____
h. _____ other ____

110. If you have experienced a decrease in fear, to what do you attribute this?

111. Have you developed any unusual fears or phobias since your asssult that are not rape related (i.e. fear of heights, fear of snakes, etc.) [Ask open-ended, then categorize; 0 = no, 1 = yes for each category]

a. _____ heights (vertigo) ____
b. _____ water ____
c. _____ snakes (reptiles) ____
d. _____ spiders-bugs ____
e. _____ rodents ____
f. _____ agorophobia (fear of opened spaces) ____
g. _____ crowds ____
h. _____ other ____

112. Is your level of depression different now that it was before your assault? Please indicate response on following 7-point scale, 4 equals no change. (If no, go to #118)

1	2	3	4	5	6	7	
much less depression			no change			much more depression	____

113. If you have experienced an increase in depression since your assault, is the depression triggered by certain types of things or situtions or do you feel that your depression is more general in nature, causing you to become more easily depressed in all situations?

1. specific
2. general
3. both at different times ____

114. What sort of things make you feel depressed? [Ask open-ended, retain o-e response; then have woman review catagories below: 0 = no, 1 = open-ended, 2 = cued for each category]

a. _____ depressed about how rape altered her life
b. _____ wonder why happened to her
c. _____ depressed about the "negative" changes rape has made in her
d. _____ other

115. If your level of depression has changed since your assault, do you find this change disruptive? Please indicate response on the following 7-point scale.

1	2	3	4	5	6	7
not at all disruptive			moderately disruptive			very disruptive

116. If you find your change in depression disruptive, how is it so? [Ask open-ended, then categorize; retain the o-e response: 0 = no, 1 = yes for each category]

_____ difficulty concentrating, attending, etc.
_____ difficulty functioning adequately (can't do daily activities well, etc.)
_____ totally non-functional (sits and stares, etc.)
_____ lack of energy, lethargy, etc.
_____ disrupts family
_____ withdrawn, numb, etc.
_____ frustration
_____ other

117. If you have experienced a decrease in depression, to what do you attribute this?

118. How do you define "vulnerable" and what things make you feel this way? [Ask open-ended first, retain o-e response; then have woman review categories below; 0 = no, 1 = open-ended, 2 = cued for each category]

a. _____ feeling physically inadequate to protect self
b. _____ being in situation where assault is possible
c. _____ not having control in situations
d. _____ being alone
e. _____ being around strange men
f. _____ new situations
g. _____ other

119. How often do you feel vulnerable?

1. _____ never
2. _____ very rarely but occasionally
3. _____ once a month
4. _____ several times a month
5. _____ once a week
6. _____ several times a week
7. _____ once a day or more
8. _____ it varies

120. Do you feel that your tendency to notice elements in the enviroment that make you feel vulnerable has incressed since your assault? Please indicate response on the following 7-point scale.

1	2	3	4	5	6	7
no change			moderate increase			very large increase

121. What kinds of things do you do to feel less vulnerable? [Ask open-ended, then categorize; retain o-e response, 0 = no, 1 = yes in each category]

a. _____ instrumentsl responses involving people (someone come to stay, etc.)
b. _____ instrumentsl responses not involving people (dogs, guns, locks, etc.)
c. _____ alert, cautious, try not to panic, etc.
d. _____ other

122. How effective are the things you do to feel less vulnerable? Plesse indicate response on the following 7-point scale.

1	2	3	4	5	6	7
very effective			moderately effective			not st all effective

123. This question concerns how safe or unsafe you felt, or how vulnerable you felt to attack, right before you were raped. We are interested in how safe you felt in the ssssult environment before you became aware of signals which indicated thst you might be attacked; that is before you heard unususl noises or before you heard the rapist approaching. Please use the following scale to indicate your response.

1	2	3	4	5	6	7
very safe			moderately safe			very unsafe

124. If you were in the ssme or a similar environment now how safe/unsafe would you feel? Please indicate your response on the following 7-point scale.

1	2	3	4	5	6	7
very safe			moderately safe			very unsafe

125. Do you feel that because of the assault you engage in any behaviors to make yourself less attractive to men or to discourege them from approeching you? If yes, what is the nature of these beheviors? [Ask open-ended, then cetegorize, retain o-e response; 0 = no, 1 = yes for aach catagory]

a. _____ alter physical eppearance (hair, dress, etc. ___
b. _____ elter interpersonal strategies (less sociable to men, ignores strange men, etc.) ___
c. _____ other ___

126. This question refers to how much control you felt thet you had ovar your personal safety/security before the rape. Thet is to whet degree did you fael thet you had the power to insure your own safety/security? Pleese indicate your response on the following 7-point scale. ___

1	2	3	4	5	6	7
very much control			moderate			very little control

127. How much control do you now feel that you have over your parsonal safety/security? Please indicate your response on the following 7-point scele. ___

1	2	3	4	5	6	7
very much control			moderate			very little control

128. What would you recommend to a woman who had just experiencad a repe es being most helpful in terms of her overall (or continuing) adjustment as a rape survivor? [Ask open-ended, then cetegorize; retain o-e responsa; 0 = no, 1 = yes in aach category]

e. _____ do not take the blame for the asseult ___
b. _____ think positivaly of self ___
c. _____ don't withdraw (try to go about normal pre-rape activitias, etc.) ___
d. _____ be a survivor ___
e. _____ seek support-help. Don't try to handle alone ___
f. _____ seek feminist counseling/support ___
g. _____ other ___

129. Do you feel that there are ways that the integration of your rape experiance may have had positive affects on you? [Ask open-anded, then categoriza, retain o-e responsa; 0 = no, 1 = yes in each category]

a. _____ able to help others through similer experiences
b. _____ beceme more ewere of women's rights
c. _____ knows thet is eble to survive herd things
d. _____ increesed sense of psychological strength
e. _____ drew them closer to some people
f. _____ new senses of priorities, realized whet importent in life
g. _____ other

RAPE ASSESSMENT SCHEDULE: DEVELOPMENT AND PILOTING

by

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AN ABSTRACT OF A MASTER'S THESIS

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Abstract

Twenty-four long-term survivors of rape participated in a project to develop and pilot a semi-structured interview schedule to be used to assess the very long-term effects of rape on survivors' psychological functioning and life-style. Long-term was defined as three or more years post-assault. The completed instrument, called the Rape Assessment Schedule (RAS), includes both quantitative and qualitative items and is estimated to take two and one-half hours to administer. Pilot data from nineteen of the survivors (mean post-assault interval=7.72 years) indicated that the effects of rape can endure for years. In general, these effects paralleled the shorter-term effects of rape documented in the psychological literature and included the occurrence of nightmares and intrusive, rape-related memories, changes in levels of fear, anxiety, anger and depression, sexual dysfunction and various life restrictions. The data also indicated that, in the majority of cases, these effects are dynamic in nature and are cued by specific environmental stimuli. The behavioral effects of rape described herein are conceptualized as avoidence/escape strategies in the context of two-factor learning theory. In addition, the survivors' reactions to rape were compared to reactions to other traumas as defined by the Post Traumatic Stress Disorder.